Funer

iclan; The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial-transit Vital Records, P.O. Box 68760,

Division of	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directorial of the funeral direction.
CA DH	St Regist

	-	For State Of Mary  State Registrar		epartment of F Certificate of I			. No.	
		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	3. Time of Death
cian dical		Homer Lee Buckles				August 6	, 2009	7:44 A M
iner	1	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County o	
		13817 Old Indian Head Rd.  5. Social Security Number 6. Sex 7. Age (In	yrs. last birthd		andywine			ce George
al or		579-74-8202 1□XM 2□ F 5	6 Yrs	Months Days	Hours Min.			9. Birthplace (State or Foreign Country) Tennessee
	- 1-	Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town o	r Location				10d. Inside City Limits
ţ	5	Maryland Prince George				1 ves 2 No		
Director		10e. Street and Number		Brandywine 10f. Zip Code		100	g. Citizen of Wi	nat Country?
<u></u>	2	13817 Old Indian Head Rd.		206	13		Unit	ed States
Finoral		11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>		Specify Yes or No- to Rican, etc.)		- American Indian, , White, etc.
		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ∐Yes 2 ⊠ No			Specify:	
Completed by	200	15. Decedent's Education (Specify only highest grade completed)	16a. De (G	ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	ation during most of wo	rking 16	6b. Kind of Bus	siness/Industry
1	5	Elementary/Secondary (0-12) College (1-4or 5+)		Co				Private
A S	2	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Ma	aiden Surname	)
F 6	2	Homer Johnson				Paulin	e Buckl	.es
		19a. Informant's Name/Relationship (Type. Print) Pauline Boney/ Mother		Mailing Address (Street B17 Old Ind				
		I M Burial 2   Cremation 3   Hemoval norm State	Ob. Place of Dicemetery,	isposition (Name of crematory or other placeurrection	, 110	gust		City or Town, State
oj l	-	4 Donation 5 □ Other (Specify)  21. Signature of Funeral Service Donates	100	emetery 22: Name and Addre	ss of Facility	_2009		, Maryland Home, Inc.
ODC		Tai DIL 10 (x Pall	211	_4001 Benr				, DC 20019
			Cardia	c Death	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
r		Due to (or as a co	en esco	al Disease	on Dial	veie		
Examiner	,	Sequentially list conditions if any, leading to limits and cause. Either Underlying Cause (Disease or injury that initiated events calls)						
	í	resulting in death) Last Due to (or as a co						
Pedical	5	u						
Physician/M	) Sicialization	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	e of delivery nth Day Year					
		Part II. Other significant conditions contributing to death but no	ot resulting in th	ne underlying cause giv	en in Part I.	23e. Did toba	acco use contri	bute to the cause of death?
2						1 🗆 Yes	2 No	3 Probably 4 Unknown
Completed by	2					24a. Was an autopsy perform	ed? d	Vere autopsy findings available rior to completion of cause of eath?
B S		25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ath (Check only one		☐Yes 2 ☐No
L P		examiner? 1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient	2 ER/Outpa	atient 3 DOA Oth	Or:	Home 5 X Resider		er (Specify)
L. uoite		27. Manner of Death  1 🔀 Natural 5 Pending investigation  28a. Date of Injury (Month, Day, Ye	ar) 28b. Tim	ury Wor	ry at k? Yes 2 ∐ No	28d. Describe how	v injury occurre	bd
Certification:		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (5	At home, farm Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical C		29a. Certifier (Check only one)  1 Certifying Physician: To the best of many decided Examiner: On the basis of examiner stated.	amination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and ma te and place, a	nner as stated. and due to the cause(s)
M		29b. Signature and title of certifier	101	29c. Licens				(Month, Day, Year)
		30. Name and address of person who completed cause of death Kamlesh Gupta, M.D. 106 Irvin		ype, Print)				-
tate		31. Date filed (Month, Day, Year) / 32. Registrar's	Signature		CII TOWEL	, DEC. HI	J WDQ 2	.0010
strar			Jak!					

# Baltimore, Maryland 21215-0036

The state of the s				For State Registrar	State of Ma	ii yiaiiu / L		cate of l		a mon		eg. No.	200	9 2	750
ALIAN   DEVENUES   Colly   South of Location of Death   Part   College   Colly   College   Col		Physici	an	1. Decedent's Name (First, Middle, Las	st)					1	<b>Month</b>	Day		2.0	
DOCTORS COMMINITY HOSPITAL    Linking   Linkin						BEVERI					y GUS	_7			PM
Social Security Number   Sec		Examir	ner		, and the second	_	4b.			eath			•		
The control of the							thday) If			Hrs.   8. [	ate of Birth				
10.5 Size   10.6 Country   10.6 Factor   10.	9			308-46-6295			Mo	nths Days	Hours M	Ain.	Month, Day,	Year)			
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Specify only implient grade completed   Specify only implient grade   Specify   Specify only implient grade completed   Specify only implient grade completed   Specify only implient grade   Specify   Specify only implient grade   Specify   Specify only implient grade   Specify   Spec	4	or 28	ië				10	of. Zip Code			1	0g. Citi	izen of What C	ountry?	
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Physician   Phys	ָרָ הַ	natur	eted	15. Decedent's Ed	lucation	16a				workina	1	16b. Ki	nd of Business	s/Industry	
Security	7	nthin ne. nan "i	Jg III		College (1-4or 5-	+)	`life. DO N	IOT use retired	1)				00 00	HOOT C	
WILLIAM L. BEVERIDGE  WILLIAM L. BEVERIDGE  WILLIAM L. BEVERIDGE  19th Making Address (Street and Number or Rural Route Number. City or Town, State, 2g Code)  19th Making Address (Street and Number or Rural Route Number. City or Town, State, 2g Code)  19th Making Address (Street and Number or Rural Route Number. City or Town, State, 2g Code)  19th Making Address (Street and Number or Rural Route Number. City or Town, State, 2g Code)  19th Making Address (Street and Number or Rural Route Number. City or Town, State, 2g Code)  20th Method of Disposition  1	7	lled w Hygie her ti	S	17. Eathor's Name (First Middle Last			PS	YCHOLO		Name (Fir	st. Middle. I	Maiden		HOOLS	
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20. Like to 1. Depth of the complete of the co	<u> </u>	should nd Me mark matic	F				o. Mailing Ac	Idress (Street	and Number o						
20. Method of Disposition   Date   20. Location - City or Town, State	S	alth ar 27 is r trau						•				-			
Physician Medical Examiner  Ph	ē,			20a. Method of Disposition		20b. Place o	f Disposition	(Name of	1					r Town, State	•
Physician Medical Examiner  Ph	בַּ	5n <del>∠</del> − 0		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	IRemoval from State  y)		•		i	-13-20	009	RIV	ERDALE	, MD.	
Physician / Medical Examiner  Physician / Medical Examiner / Month Day /	Balt	させせき .		21. Signature of Funeral Service Licer	111 1	•	22. Na CHA	me and Addre MBERS	ss of Facility FUNERAL	L HOM	E & CI	REMA	TORIUM	, P.A.	
Sequentially list conditions, any kear's of the minicipal cause father fundering that initiated events flurry that initiated events flurry resulting in death Last    Sequentially list conditions, any kear's of the minicipal cause gluence of the cause o				shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	e.	not enter th	e mode of dyir	ng, such as car					Approxii Interval	mate Between nd Death
Due to for as a consequence off:  Gashurks final Bleady   Sequentially list conditions cause (Disease or Injury hat inflated events resulting in death) Last  Consider the property of the pro							or):								
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month Day Ye   1   Yes 2   No 3   Probably 4   Pregnant at time of death   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unit probable   25e. Was case referred to medical examiner?   25e.	1 15		ĕ	Sequentially list conditions,	U.		of):		24						
FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month Day Ye   1   Yes 2   No 3   Probably 4   Pregnant at time of death   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unit probable   25e. Was case referred to medical examiner?   25e.	) 1	cured nd ransit	ami	that initiated events	· Gas	poens	les hi	200	Buea		7				
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The state of the s	2/8	cate c chysic the b	dica		d	91	au	0/6							
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Second   Completion of cate death?   Completion of cate death.   Completion of cate	У. Н.	res mat t signed by be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting i	in the underl	ying cause giv	en in Part I.						of death?
25. Was case referred to medical examiner?	COL	w requi	leted							_			24h Were :	autopsy findir	nos available
25. Was case referred to medical examiner?  1		ate h	Comp								perfor	med3/	death	?	of cause of
The part of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred   28d. Describe how injury occurred   28d. Date of Injury   28d. Date of Inju	VIE	ician certifi ector,	(a)	examiner?	Hospital:			Oth	or:						_
Matural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   5	o	ral d	II-II		mpatie			LI DOA	4 LI Nursii					pecify)	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ם ק		ţi	1 Natural 5 ☐ Pending	(Month, Day	y, Year)	Injury					on nga	.,		
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	DIVISI	after dear Director d in by the	ertifica	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At home, fo c. <i>(Specify)</i>	arm, street,	l factory, office						Rural Route I	Number,
5 Janie Hem 065 409 8712109	1	e Hospita 24 hours E Funeral etely fille		(Check only 2 Medical Exa	miner: On the basis of	f examination a	je, death oc nd/or invest	curred at the tigation, in my	me, date and popinion, death	place, and occurred a	due to the out the time, of	cause(s	s) and manner d place, and d	as stated. ue to the cau	se(s)
5 Janie Hem 065 409 8712109	4	vithin To the	Me					29c. Licens	se number		- 2	29d. Da	ate signed (Mo	nth, Day, Yea	ur)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fasi   Nemu 8118 Good Luck Road had had had had had had had had had h	<b>)</b>	5		I favie h	Cem			06	5909	9		A.	87121	09	
State Registrar  AUG 13 2009  32 Registrar's Signature  Aug 1 3 2009  32 Registrar's Signature  Aug 1 3 2009		_		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Print	LUCK	ROAD	1 4	4 W H.	AN,	ND	2070	06
DUG BY LOVY AND / / //				31. Date filed (Month, Day, Year)  AUG 13 2	32 Registra	ar's Signature	par	10							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:37 M **Physician** Belton Auc Yolanda Garcia 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's 511 Sandy Place Oxon Hill Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2KXF DC 28 1965 Wash., 579-82-5057 Apr 44 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Expraise must be notified at once. Prince George's Oxon Hill 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20745 USA 511 Sandy Place Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: ۾ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Manager Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearlie Barber Daniel Belton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 511 Sandy Place, Oxon Hill, MD 20745 Shakia Belton/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 15 2009 Landover, MD Harmony Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ervical /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sepital or Attending Physician: The law requires that the death certificate be executed hours after death.
uneral Director: After this certificate has been signed by the attending physician and the burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 🛣 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) P.0. After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pital Drive,

00

3001

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** 1840PM Frederick Bowden George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death **Examiner** Mayal 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthda) **Funeral** Year) Months Days Hours 1 🖾 M 2 🗆 F 213-42-1165 66 04/22/1943 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Examiner must be notified at 1 X Yes 2 No Salisbury Maryland Wicomico Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 1331 Middle Neck Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces? 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: Army 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) state highway Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) administration worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marjorie Catherine Insley Donald Preston Bowden, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1331 Middle Neck Dr., Salisbury, MD 21804 Margaret Bowden/spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/14/09 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on e sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Dug-te Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760. IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2☐No 9 Unknown 9 Unknown but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? Yes 2 ANo 1 ☐ Yes this certificate 2 No 1 Yes : After this certifications and director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 panpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Af

State Registrar

31. Date filed (Month, Day, Year) AUG 1 3 2009

29b. Signature and tif

30. Name and address of

of certifier,

29a, Certifier

erson who completed cause of 100 E. 32. Registrar's Signature

SALIS bury:

eath (Item 23a) (Type, Print)

md. 21801

29d. Date signed (Month, Day, Year)

K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D34768

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 4:56 A CULLEN August HARRY **EUGENE** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 ★ M 2 □ F 219-62-8781 54 Director October 16, 1954 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is in the state of the state of the state of the state of the state. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Maryland Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7914 Public Landing Road 21863 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 28 Married Baltimore, Maryland 21215-0036 If Yes, Give X Year or Dates: Specify: White 1 ☐Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Worcester County Elementary/Secondary (0-12) College (1-4or 5+) Sherriff's Office 12 Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ William Edgar Cullen Ida Ruth Howard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Serman Cullen (Wife) 7914 Public Landing Road - Snow Hill, MD 21863 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory : 8/14/2009 Salisbury, Maryland 22. Name and Address of Facility Robert H. Bradshaw, Ar. 306 W. Main St. - Crisfield,
Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician CAMPIONASCULLAK HYPERTENSINE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 🖼 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ▼Yes 2 □ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Man or of Death 28c. Injury at Work? Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier SO Name and address of person who completed cause of death (Item 23a) (Type, Print)

EMUIN CASIMMENT MO 1324 OD OCEMNUTY BND. BENEIN, MD21811

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Regjstrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) Year **Physician** August 2049 1325 Ann ouncel /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Easten Hospital 1 albot memonal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🛛 F Yrs. Director 214-32-1538 Maryland 09/26/1933 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment on the notified at once. 1 ☐ Yes 2 👿 No Director Talbot Cordova 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 11469 Three Bridge Branch Road 21625 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be C. Temple Rhodes Mabel Ewing 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11469 Three Bridge Branch Road, Cordova, MD 21625 Phillip E. Councell/husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 01d St. Joseph s
22. Name and Address of Facility 4 ☐ Donation 5 ☐ Other (Specify) 108/12/2009 Cordova, MD 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 31. Joseph E.S.P. STROWSKI. 200 South Harrison Street Faston, MD enter the mode of dying, such as cardiac of respiratory arrest; 21,6 TL te 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se puentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 ☑No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been sign rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2.☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No nours after death.

neral Director: After this c 1) Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 24 hours a 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one)

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the

State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registrar AMEND#19aperFH,8-17-09, BW, McCo Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year August **Physician** PM 138 2009 rancis Campi (0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Days Hours **№** M 2 🗆 F 5,1936 PA 173-30-0320 April Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Exacting must be notified at 1 ☐ Yes 2 ☑ No Director Brookeville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number USA 23a 20833 18704 Tanterra Way Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Mayes 2 cl No
1f Yes, Give
Year or Dates: 1959–87 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. items Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2√2 No Specify Specify: White ð 3 Widowed 4 X Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Lieutenant Colonel U.S. Army 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Giandonato Venanzio Campi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun daughter /<del>Sister</del> 368 Blackhawk Lane, Lafayette, CO 80026 Louise C. Petrarca 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Aug. 11 1 ₺ Burial 2 ☐ Cremation 3 Chemoval from State Matthew Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Conshohocken, 21. Sign of re of Funeral Service Licens 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one dause on each line. Silver Spring MD Approximate Interval Between Opset and Death Immediate Cause (Final 2es **Physician** piratory Fai disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner estrictive Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a punsequence of Examiner a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Puneral Director: After this certificate has been signed by the aftending physician and letely filled in by the thoraid director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie ٩ 9+1

Registrar DHMH 17 Rev 1/2001

State

#201

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Corove

15225 Shady (

31. Date filed (Month, Day, Year, AUG 13

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 3:02 A

1. Decedent's Name (First, Middle, Last) Day 2009 Month **Physician** August 8, David Michael Campbell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1610 Knoxville Rd. Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-5-1953 **Funeral** Days Hours 1**X** M 2□ F 216-60-9626 55 Pennsylvania Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 23a or 28a-f show event, the Midical Examiner roust be notified at Directo Maryland Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1610 Knoxville Rd. 21037 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Lineman Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Thomas John Campbell, II ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jil A. Campbell/ Wife 1610 Knoxville Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Kalas Crematory 8-11-09 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

**Physician** /Medical Examiner

physician ar s the burial-tr

attending pl for use as t

rector, page 2

within 24 hours after death

To the Funeral Director: A completely filled in by the f

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

disease or condition resulting in death)

21. Signatur Service Licensee

23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final

replications that caused the death. Do not enter the mode of dying, such one cause on each line.	n as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Deat
Due to (or as a consequence of):	
Due to (or as a consequence of):	
CDue to (or as a consequence of):	
d	
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery

22. Name and Address of Facility

10d. Inside City Limits

George P. Kalas Funeral Home

2973 Solomons Island Rd. Edgewater, MD 21037

1 ☐ Yes 2 ☑ No

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? yes 2 No Medical Certification: To Be

25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	OA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manne Death 1 1 atural 5 ☐ Pending 2 ☐ Accident investigation	n M	28d. Describe how injury occurred Work? 1 □ Yes 2 □ No								
3 Suicide 6 Could not b 4 Homicide determined		, office 28f. Location (Street and Number or Rural Route Number City or Town, State)	ar,							
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29a. Certifier (Check only one)	1 ☐ Certifying Physician: To the best of my knowledge, death 2 ☐ Medical Examiner: On the basis of examination and/or inv and manner stated.		
,	and marmer stated.		
OOh Cianatura an	d title of contition	200 Licongo number	20d Date signed (Month Day Year)

141) D53306 S/10/09
(Item 23a) (Type, Print)
900 Bestgate Rd ste 300 Annapalis MD 21401
Signature 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month. Day. 32. Registrar's Signature AUG 11

			For State	State of Maryl		epartment of Certificate o			gene eg. No. O O O O	0.7500
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h LUU.	3. Time of Death
ı	Physicia		Mary W. Corbin					Month 08 1	Day Year	7:35 A M
-	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	or Location of Death		4c. County of Dea	
-100			Coastal Hospice a	+ the Lak	2	Sali	Sbury		Wicor	
	Funeral		5. Social Security Number   6. Sex	7. Age (In	yrs. last birth	Months   Day	s Hours Min.	8. Date of Birth (Month, Day)	Year) Co	thplace (State or Foreign ountry)
	Director		213-16-8784	M 2MF 93		5.		2-24-1	916   MD	
	and		10a. State 10b. County	10c	c. City, Town	or Location				10d. Inside City Limits
	Mary -f sh	ţō	MD Wicomico	, E	Eden					1 □Yes 2 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	h with	a D	31942 Flowerhill	. Church P	≀oad	21822	2	U	.S.A.	
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diesi Evaniner must be rediffed at	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Sp uban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or It		1 Never Married 2 Married	Armed Forces? 1 ∐Yes 2 Mo If Yes, Give		1 □Yes 2 🕱 N			Specify:	
8	72 hours after dea "natural", or Items dical Evaninal m	d by	3X Widowed 4 □ Divorced	Year or Dates:	160.5	Decedent's Usual Occ	nunction.		Black 16b. Kind of Business	/Industry
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72	withi	E O	Elementary/Secondary (0-12) GED	College (1-4or 5+)		ıstodian			Board of	Education
ğ	il Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surname)	
Maryland	Jid be Jental rked o	To E	John Armwood				Bertie	Armwoo	d	
ary	and Nand	-	19a. Informant's Name/Relationship (Type	оө. Print)					r, City or Town, State,	
	and 2 ealth n 27 i		Viola Jones/Nied	:e					oad, Ede	
öre	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R			Disposition (Name of crematory or other p	lace)	TA	20c. Location - City of Vest Post	
E	Pag Iment tant: I		4 □ Donation 5 □ Other (Specify)	Simoval nome of the	St.Mai	cy's Chu		-2009 <sub>E</sub>	rincess_	Anne, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other fraumatic event, the Meonce.		21 Signature of Furleral Service License	10 6 6 -		Bennie S	Smith 91	7 W. Is	sabella S	t
			23a. Part 1. Enter the disease, or compli	goop	death Den	Funeral	Home Sa	Lisbury	MD 218	O 1 Approximate
			shock, or heart failure. List only or	ne cause on each line.						Interval Between Onset and Death
8	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CORONA	RY	ARTAN	D15121	45 R		
7	Examiner			Due to (or as a co	nsequence of	DBALAI	DISTE	5.403	777	
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	outed ansit	Examiner	Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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	ertificating p		IF FEMALE:							
Box	death certifi e attending id for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of po 1 ☐ Live birth 2 ☐	Fetal death	3 ☐ Ectopic pregna			23d. Date of d Month	elivery Day Year
0	D 0 D	Physician/M	1 ☐ Yes /2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death	5 ☐ Other (specify	)	,		
σ.	law requires that the de las been signed by the a 2 should be detached t		Part II. Other significant conditions con	ntributing to death but no	ot resulting in	the underlying cause	given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Vital Records,	uires sign d be	d by						1 🗆 Y	res 2-17 No 3□1	Probably 4 ☐ Unknown
00	v requir	Completed						24a. Was	an 24b. Were a	autopsy findings available
Вe	0 T 0	ш							rmed?	o completion of cause of es 2 Ano
tal	- 23 -		25. Was case referred to medical				26. Place of Dea	1 □Yes th (Check only o		S 2194110
>	Physician: this certific ral director,	o Be	examiner?	lospital:	2 🗍 ER/Out	patient 3 DOA	Othor:	ome 5 Resid		necity) HOSPICR
J Of	fing Ph	L.	27. Manner of Death	28a. Date of Injury (Month, Day, Ye	28b. T		njury at Vork?		now injury occurred	
Ö	Attending in death. ector: After by the fune	atio	1 Natural 5 ☐ Pending investigation	(Month, Day, 10	,		□Yes 2□No			
Division	of or Attency after death Director:	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, far	m, street, factory, office	æ	28f. Location (5 City or Tov	Street and Number or i vn, State)	Route Number,
	ital or alfarent alfa		A							
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exami	sician: To the best of miner: On the basis of exa	amination and	death occurred at th i/or investigation, in r	e time, date and place ny opinion, death occu	red at the time,	date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number		29d. Date signed (Mo.	nth, Day, Year)
	70 Wit	_	and of our mor				00584		8/10/0	
			30. Name and address of person who co	ampleted cause of death	h (Item 23a) /		04	. 0	2/(0/0	1
			CHUMAN WAR	J P.O BO	× 17	3 3				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	h 4.1				
	Regist	rar	AUG 132	UUY Lensur	a p.	14 Chros				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 **Physician** 3:45 pM August 7, Alice Matson DiBlasi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot William Hill Manor - Marvel Hall Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F 94 057-14-4620 Director March 7, 1915 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any loury or other traumatic event, the Modical Excitor traust be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Director MD Talbot Easton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 Dutchmans Lane Funeral 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√2 No Specify Specify: White \$ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William C. Matson Clarissa I. Ketcham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Larsen/daughter 26233 Martingdale Lane, Easton, MD 21601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Long Island Nat'l. Cem. 8/12/2009Pinelawn, NY 21. Signature of Frineral Service Lice 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a Part 1. Enter the disease, of complications that caused the death. Do not enter the more of dying, such as call at one spiratory are strategy and strategy are strategy are strategy and strategy are strategy ar Interval Between Opset and Death Immediate Cause (Final **Physician** KNG disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) by the 9 Unknown been signed the should be detailed 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s perform certificate 1 ☐Yes 2 ☐ No W 1 ☐ Yes r this certifica 25. Wa case of re me examiner Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Lirector: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month/Day, Year) 29c. License number 29b. Signature and title of certified Name and address of person who of death (Item 23a) (Type, Print) Jehmans Lane Easten, MD 10 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 0 2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State of Ma Registrar		artment of Health and artificate of Death	Mental Hygie		07511
	Physici	an	Decedent's Name (First, Middle, Last)  RONALD DAVID	DELAU	gram	2. Date of Death Month	Day Year	3. Time of Death
me.	/Medio	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	AUGUST	6,2009 4c. County of Death	11:33A M
	Funeral Director	) 	FREDERICK MEMORIAL HOSPIT  5. Social Security Number 6. Sex 7. Ag		FREDERICK	S. 8. Date of Birth	FREDERICK	ace (State or Foreign y)
	p		Usual Residence of Decedent  10a. State 10b. County			TITITI		
	Maryla foot	ţō	MD Frederick	10c. City, Town or Lo	Middletown		10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a ist be notif	<b>Funeral Director</b>	10e. Street and Number 8022 Myersville Rd.		10f. Zip Code 21769	10g.	Citizen of What Countr	y?
9800	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exar, it we must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☑ HYes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	(Specify Yes or No- rrto Rican, etc.)	14. Race - America Black, White, et Specify: Whi	c.
Baltimore, Maryland 21215-0036	within 72 hounders. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	edent's Usual Occupation e kind of work done during most of w DO NOT use retired) penter	orking	construct	-
land 2	uld be filed Aental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Glenn Delauter	carj	18. Mother's Na	ame (First, Middle, Maid Fink	den Surname)	
Mary	1 and 2 should be Health and Mental tem 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type. Print) Donald Delauter (Broth		ing Address (Street and Number or I 5 Mt. Philip R			
imore,	Pa Int		20a. Method of Disposition  1 23 Burnal 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify)	20b. Place of Disponsion Commetery, cree Luthers	osition (Name of matory or other place) an cemetery8/1		Location - City or Tow	•
Balt	permit. Departr Importa any Inju	-	21. Sign/ture or Functal Service Licensee		Name and Address of Facility Donald B. Thom POB 18, Middle	town. MD	21769	
	Physician /Medical		29a Part 1. Euter the disease, or complications that caused thock, of heart failure. List only one cause on each lir Immediate Lause (Final disease or condition resulting in death)	the death. Do not entre.	ter the mode of dying, such as cardi	ac or respiratory arrest,		Approximate nterval Between Onset and Death
1	rate be executed whysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as d	ssection				
	atth certi attending for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome 1  Live birth 4  Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year	
rds, P.	res the signe signe pe d	þ	Part II. Other significant conditions contributing to death bu	ut not resulting in the u	inderlying cause given in Part I.	23e. Did tobao	co use contribute to the	cause of death?
		Completed	OF War area referred to the last of the la			24a. Was an autopsy performed	prior to com death?	sy findings available pletion of cause of
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1   Yes 2 □ No   Hospital: 1 □ Inpatie	ent 2 ☐ ER/Outpatier	Othor	eath (Check only one) Home 5 T Residence	e 6 ☐ Other (Specify)	
$\subseteq$	al or Attending Pt : after death. I Director: After th d in by the funeral	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 28a. Date of Injun (Month, Day			28d. Describe how i		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injubuilding, etc	ury - At home, farm, strop. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	n 24 hou n 24 hou ne Fune bletely fi	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or in	th occurred at the time, date and pla nvestigation, in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as sta and place, and due to t	ited. he cause(s)
	To #	W	29b. Signature and title of certifier		29c. License number  MDD 66599	29d. 8	Date signed (Month, D	ay, Year)
			30. Name and address of person who completed cause of de	, m) 1807	Print) HOURS YOHN (ON D)	L-SUSTE 20	2 EHENTERICA	1021/02
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. pegistra	ar's Signature	ranks			

Registrar
DHMH 17 Rev 1/2001

		4	State of Maryland / Departmen	it of Health and e of Death		- 00000	07510
			1. Decedent's Name (First, Middle, Last)	e or Death	2. Date of Deat	eg. No.	3. Time of Death
	Physicia	an	Mae Margaret Dorsey		Month August	8, 2009	12:05 A <sup>M</sup>
	/Medic Examin			Town, or Location of Deat		4c. County of Deat	
	Examin	61	Montgomery Village Health Care	Montgomery	Village	Montgo	omerv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	1 Year   If Under 24 Hrs Days   Hours   Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		215–38–7191   15 M 248 F   85 Yrs.		Oct. 26,	1923 Ma	ryland
7	www.		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
Pace	f sho	គ្ន	Maryland Wantage	mery Village			1⊠Yes 2 No
q.	r 28a	Director	Maryland Montgomery Montgo  10e. Street and Number 10f. Zij		1	0g. Citizen of What Co	untry?
4	3a o	a D	19301 Watkins Mill Rd.	20886		United St	tates
4	mean Sums 3	Funeral		dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
336	permit. Fages 1 and 2 should be filed within 72 hours after death with the maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evential must be rivilled a once.	by Fu	1  Never Married 2  Married 1  Yes 2 No If Yes, Give 1  Yes 3 ☑ Widowed 4 Divorced Year or Dates:			Specify: B1	lack
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215	an "n	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	ork done during most of wo se retired)	, mig		
Maryland 21215-0036	ygien ygien ner th	ပ္ပြ		urse's Aid	me (First, Middle, I		Private
בו בו	ital H id oth even	Be	17. Father's Name (First, Middle, Last)	18. Mothers Na		ce Dorsey	
3	d Mer narke natic	ဥ	Lee Washington  19a. Informant's Name/Relationship (Type. Print) , 19b. Mailing Addres	s (Street and Number or R			Zip Code)
Za	d 2 St th an 17 is r traur						
ē, '	tem 2		20a. Method of Disposition  20b. Place of Disposition Cermetery, crematory or	art Lane # 1	Date 1gust	20c. Location - City or	Town, State
و ا	ages entol nt: If i		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Park Lawn Me			Rockville,	Marvland
saltimore,	ermit. Pepartm epartm nportai ny injui		21. Si, ature of Funeral Service Licen ee 22. Name a	nd Address of Facility St	ewart Fu	neral Home	, Inc.
0	6 5 5 C			Benning Rd. N			20019 Approximate
		. 173	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or beart failure. List only one cause on each line.	de of dying, such as cardia	ac or respiratory an	est,	Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)  Dementia				
	/Medical Examiner		Due to (or as a consequence of):				
	-	ē	Sequentially list conditions, if any, leading to immediate b. Failure To Thrive Due to (or as a consequence of):				/
	oured Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.				
oʻ	incate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	are b hysic the bu	dical	d				
Ø ×	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of de	Nivory
Вох	e attending of for use as	sician/Me	in the past 12 months?			23d. Date of de Month	Day Year
o i	0 0 0	ıysid	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
S, P.	ned b deta	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
g ·	w requires been signo should be				1 □ Y	es 2⊠No 3□F	Probably 4 Unknown
000	The law requires that the ate has been signed by the bage 2 should be detached.	Completed			24a. Was autop		utopsy findings available completion of cause of
œ	Ine I cate ha	mo.			perfo	med? death?	s 2□No
/ita	sıcıan: In certificate rector, pag	Be (	25. Was case referred to medical examiner?		eath (Check only o	ne)	
<u></u>	hysic this c		1  Yes 2 No Hospital: 1 Inpatient 2  ER/Outpatient 3 □ [		1	lence 6 Other (Sp	ecify)
UC.	ding Ph h. After th funeral	ioi	27. Manner of Death 28a. Date of Injury 1 Natural 5 ☐ Pending (Month, Day, Year) 1 Nestigation M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	26d. Describe i	low injury occurred	
Division of Vital Record	en eat or:	lical	2 Accident 3 Suicide 6 Cold not be 28e. Place of Injury - At home, farm, street, facto		28f. Location (S	Street and Number or F	Rural Route Number,
<u>.</u>	tal or Att	Certification: To	4 ☐ Homicide determined building, etc. '(Specify)		City or Tov	in, State)	
	To the Hospital or within 24 hours after To the Funeral Directory completely filled in b	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, death occurred to the best of examination and/or investigation and/or investigation and/or investigation and/or investigation.	d at the time, date and pla on, in my opinion, death oc	ice, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
:	To the within To the Somple	Me		9c. License number		29d. Date signed (Mor	nth, Day, Year)
	- 1 0			Н 0051280		8-12	10-
1	14		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		06 = =		0050
1	- 1		Anushiravan Dadgar, D.O. 10110 Molecular	Drive Ste. 2	ub Rockv	LITE, Md. 20	0000
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  AUG 1 4 2009  August 32. Registrar's Signature  32. Registrar's Signature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** August 8, 2009 Mary Elizabeth Dawson-Steverson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🕅 F 68 DC 578-54-0348 09/10/1940 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show ral", or Items 23a or 28a-f shov Examiner must be solified at 1 XYes 2 No Directo Maryland Montgomery Germantown the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 20874 United States 18889 Warring Station Rd. # 209 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must 3 ance. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 1 □ Never Married 2 □ Married Specify: African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes. Give 2 3 ☐ Widowed 4 🖾 Divorced Year or Dates: American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Group Homeowner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Stubberfield Thomas Dawson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 8115 East Beach Dr. NW Darlene Mathis Gardner/Daughter 20c. Location - City or Town, State August 15 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee's Crematory 2009 s Crematory 2009 Clinton, Maryland Rame and Address of Facility Stewart Funeral Home, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licens 4001 Benning Rd. NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Arrhythmia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed prior to completion of cause of death? 24b. Were autopsy findings available 24a. Was an autopsy pertormed? 1 □ Yes 2 ☑ No certificate 1 Tyes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t 5 Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Property Prector: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2

State

31. Date filed (Month, Day, Year) AUG 1 4 2009

29b. Signature and title of

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

MD 9901 Medreal Center Drive, Rockville, Md.

29d. Date signed (Month, Day, Year)

2009

20850

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		Oldio of IV	iai yiai i		rtificate of	Death	R	eg. No.			
	Physicia	20	1. Decedent's Name							2. Date of Deat Month	Day	Year	3. Time of	
1	/Medic			HOBART E						Aug		009	5:32	PM'
	Examin	er	4a. Facility Name (li		e street and numbe Care –		inec		or Location of Dea: aston	tn		ty of Death $\Gamma alb$		
	Funeral		5. Social Security N			age (In yrs. la		If Under 1 Year	If Under 24 Hrs	8. Date of Birth			intry)	or Foreign
	Director		217-12-48	896	ex 7. ₽	87	Yrs.	Months Days	Hours Min	8. Date of Birth (Month, Pay,	1922	Cor	MD	
,	pu »		Usual Residence of 10a. State	Decedent 10b. County		10c. City.	Town or Lo	ocation					10d. Inside C	ity Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modical Evantion must be notified at apprecia	ō	MD	TALBOT		1.001.01.0,		STON					1XX es	2 □ No
	r 28a	Director	10e. Street and Nur					10f. Zip Code		1	0g. Citizen of	What Cou	ıntry?	
	th with	alD	610 DUT	CHMANS LA	NE			2160	)1		US	SA		
	tems	Funeral	11. Marital Status		12. Was Deceder Armed Forces 1 <b>XX</b> es 2	nt Ever in U.S	3. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? ( ban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Ra	ace - Amer ack, White,	ican Indian, , etc.	
36	rs afte	by F	1 ☐ Never Marri 3 XXidowed	ed 2 Married 4 Divorced	If Yes, Give Year or Dates	1942	-46	1 □Yes 2 💢 💢 🔾	Specify:		Spec	ify: WH	ITE	
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George Eichnor altimore, Maryland 21215-0036	is 1 and 2 soft Health a item 27 Is		GEORGIAN		DAUGHT		l			MANCHES'				
rg ore	ges 1 at of H if iter or oth		20a. Method of Disp 1 Burial 2 €		Removal from Stat	e I		osition (Name of matory or other pla		Date	20c. Location			
tinge Time	iit. Pa urtmer ortant: njury		4XXX onation 21. Signature of Fu	5 Other (Special Service Lice		MD		OMYBOARD  2. Name and Add		-2009	BALTII			=-
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			23a, Part 1, Enter t	he disease, or com	plications that caus one cause ov each	ed the death	. Do not er	nter the mode of dy	ring, such as cardia	ac or respiratory an	rest,		Approxima Interval Be	te tween
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	/Medical Examiner		resulting in death)		Due to (or a	as a convequ	ence of):	, ,						
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Division of Vital Records,	or At after d Direct in by	Certification:	4 ☐ Homicide	determined	Zoe. Flace of	Injury - At ho etc. <i>(Specif</i> )	me, farm, s /)	treet, factory, office		28f. Location (S City or Tow	street and Nu vn, State)	mber or Hi	urai Houte ivui	mber,
_	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier	12 Certifying P	hysician: To the be	est of my know	wledge, dea	ath occurred at the	time, date and pla	ice, and due to the	cause(s) and	manner a	s stated.	(-)
	he Ho in 24 h he Fu pletely	Medical	(Check only one)	2☐ Medical Exa	miner: On the basi and manner	s of examina stated.	tion and/or	investigation, in my	opinion, death oc					(S)
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	VA+4		30. Name and add	ress of person who	completed cause of	or death (Item	723a) (Type	TCHMAN	S LANE	EAST	ION M	Δ.	2160	1
	Sta	ate	31. Date filed (Mor	nth, Day, Year)	32. Regi	istrar's Signa	ture	TCHMAN	J 18111C	~ (3)	-14	-		
	Regist	rar		AUG 072	009 De	ue ,	8. A	aver						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009<sup>Year</sup> August 8, 12:02A M Martin Erlebacher 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 15816 Laughlin Lane If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days 1X M 2 ☐ F Jan 1, 1930 073-22-8323 79 Germany Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number **USA** 15816 Laughlin Lane 20906 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Korean Year or Dates: War 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Architect Firm Business Owner 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claire Lowenstein Gustav Erlebacher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15816 Laughlin Lane Silver Spring, MD 20906 Elza Erlebacher/wife 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 08/11/09 Woodbine, MD 21. Signature of Funeral Service License G8iling Montes Cremation Service P.O. BOx 784 MD 21029 MO1251 Beverly L. Heckrotte, P.A. Clarksville, Approximate Interval Between Onset and Death 5 Years 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Cell Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 ZWo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760. o signed by the ar this certificate has but director, page 2 sl

nours after death.

neral Director: After this c 24 hours a To the Hosp within 24 hou To the Fune completely fil

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

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Funeral

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Completed

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic event, If we wante.

**Physician** /Medical

Examiner

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 | Homicide

31. Date filed (Month

Baltimore, Maryland 21215-0036

10+1

State Registrar 29b. Signature and title of certifier

5 ☐ Pending investigation

6 □ Could not be

determined

AUG 12 2009

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRE MART ISASELLA

32. Pegistrar's Signature

28a. Date of Injury (Month, Day, Year)

HE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 11, 2009 7:15 PM August Dolores Jane Furgal 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Union Hospital of Cecil County Ceci1 E1kton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Hours Months Days 1 □ M 2 🛛 F Yrs. July 30,1927 Massachusetts 82 026-20-5353 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2X No North East Ceci1 Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21901 85 Cedar Hill Circle 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare 12 Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Emma Marie Champagne Edward Joseph Morin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 85 Cedar Hill Circle, North East, Maryland 21901 Loriann Everett 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 □Removal from State August 17, 4 ☐ Donation 5 ☐ Other (Specify) Bear, Delaware 2009 21. Signature 1 Fuperal S 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory are shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WIMDHATY DIGERSO Due to (or as a const quence of): unknown 515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the gause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 nknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

requires that the death certificate be executed Records, Vital Physician: ō or Attending Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or items 23a or 28a-f show aminer must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Examiner once.

**Physician** /Medical

Examiner

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death

Hospital

24 hours after death e Funeral Director:

within 24

funeral director,

filled in by

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attending physician

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

one)

4 Homicide

(Check only

Maryland 21215-0036

Baltimore,

Director

Funeral

þ

Completed

Be ပ

10

State Registrar 29b. Signature and title of certifier

6 ☐ Could not be determined

and manner stated.

29c. License number

1 💆 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ame and address of person who completed cause of death (Item 23a) (Type, Print),

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 - State Registrar

10a. State

**Physician** 

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

703-07-1074

Usual Residence of Decedent

John LeRoy Fairbank

4a. Facility Name (If not institution, give street and number)

7644 Quaker Neck Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death :

Bozman If Under 1 Year

Months

Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

91

4b. City, Town, or Location of Death

If Under 24 Hrs.

Hours

2. Date of Death

8. Date of Birth (Month, Day, Year)

04/23/1918

August

Day

2009

4c. County of Death

Talbot

5,

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

New Jersey

7:35 P M

State of Maryland / Department of Health and Mental Hygiene

			for State Of Mar S		rtificate of L			eg. No. 2	09	27518
	Physici	_	Decedent's Name (First, Middle, Last)  Miley Adina	Facev			2. Date of Dear Month		Year <b>2009</b>	3. Time of Death 6:52 aM
*	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	racey	4b. City, Town, or	Location of Death	gas v	4c. Count		
3	Examin	C:	Washington Adventist Hospital		Tal	koma Park			Montgo	ne <del>ry</del>
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🗷 F 7. Age (	76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 17	Year)	Coun	lace (State or Foreign try) amaica
	and		Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Lo	cation		-		11	Od. Inside City Limits
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	the 1	Director	Maryland Montgomery  10e. Street and Number		10f. Zip Code	rener sourg_	1	0g. Citizen of	What Coun	try?
	h with	al D	7312 Tarfside Lane			20879			U.S.	.A.
	ems :	Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
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21	T the	Completed	5+		Registered				Health	Care
Maryland	ev d stal	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			me)	
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Ma	d 2 sho th and t7 is ma trauma	İΠ	19a. Informant's Name/Relationship (Type. Print)  Ian Facey, Sr Son		interhaven					Code)
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9	. Pages 1 and ment of Health ant: If Item 27 jury or other t		1   Burial 2 □ Cremation 3 □ Removal from State  □ Donation 5 □ Other (Specify)		aven Cemete	i _	/2009	Silver S	bring.	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signatur, of Funeral Service Licensee	22	2. Name and Addres	ss of Facility	ome. Inc.			
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	Physician	6 9	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	-06%						Interval Between Onset and Death
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f V	ys dir	70 B	examiner?** 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient	2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Resid	lence 6 □0	ther (Speci	fy)
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÷	or Atten after deatl Director; in by the	Certification:	4 Homicide determined 28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory, office		City or Tow	n, State)	nber or Huri	al Route Number,
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	To the H within 24 To the F complete	Medical	one) and manner state		29c. License			29d. Date sigr		
		-	29b. Signature and title of attifier	~		1506 L		6 - 1	C - C	9
•	$\nu$		30. Name and address of person who completed cause of dea	th Vitem 23a) (Time		er Saingh,	₩ D	6	, -	2 - 2 //
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	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar	s.Signature	ales					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 200<sup>Ye ar</sup> August 10, 5:15 P Barbara Anne Gunther /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 511 Brunswick Street Brunswick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | Mar 14, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 1950 Director 59 Maryland 214-56-2734 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director MD Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Brunswick Street 21716 USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Computer Analyst Information Technology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Edward Gunther Maude Estelle Jones မ 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sister Eileen M. Gunther/ Brunswick, MD 21716 511 Brunswick Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page:
Department o
Important: If any injury or
once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 08/11/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 210

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death

Control of the Control o 21. Signature of Funeral Service License the 23a. Part 1. Enter the rus ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart is liure. List only one cause on each line. Immediate Cause (Final Metastatic Rectal Cancer 32 months disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immunity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2X No 9 Unknown 9 Unknown ⋧ Be Completed Certification: To

Examiner and I-transit or Attending Physiclan: The law requires that the death certificate be executed attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, signed by the a certificate has been s rector, page 2 should After t To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Mental Escripter or filled at ury or other traumatic event, the Mental Escripter or filled at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Hygiene. other than "natural", or items 23a or 28a-f shov ent, the Medical Examirer must be notified at

Part II. Other significant co	onditions c	ontributing to death but not resultin	ng in the underlying caus	e given in Part I.		se contribute to the cause of death? No 3 Probably 4 Unknown
					24a. Was an autopsy performed? 1 □Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to m	edical			26. Place of Dea	th (Check only one)	
examiner? 1 ∐ Yes 2 [X]No		Hospital: 1 ☐ Inpatient 2 ☐ ER	t/Outpatient 3 DOA	ome 5X Residence	6 ☐ Other (Specify)	
	Pending nvestigation	(Month, Day, Year)	Bb. Time of lnjury M	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred
	Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, of	fice	28f. Location (Street an City or Town, State	d Number or Rural Route Number, )
29a. Certifier 1 💢 Ce (Check only one) 2 Me	ertifying Ph edical Exan	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death occurred at the and/or investigation, in	the time, date and place my opinion, death occu	e, and due to the cause(s arred at the time, date and	and manner as stated. I place, and due to the cause(s)

EG-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

unles

Michael J. Purtell, M.D. 5505 Hopkins Bayview Circle Suite 100 Baltimore, MD 21224

29c. License number D19714

29d. Date signed (Month, Day, Year)

August 11, 2009

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 2 2009



			For State Of Mar State Registrar	•		ificate of L			Glen Reg. N	SAUC	27520
	Dhysisis		1. Decedent's Name (First, Middle, Last)					2. Date of De Month		ay Year	3. Time of Death
	Physicia /Medic		REMEDIOS SAWI GRANETA					AUG		2009	4:57 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	משישינ			Location of Death		40	c. County of Death  MONTG	OMEDV
1	-		NATIONAL NAVAL MEDICAL CEN           5. Social Security Number         6. Sex         7. Age (	ILEK In yrs. last birth	hdav)	DE.	If Under 24 Hrs.	8. Date of Bir (Month, Da	th		place (State or Foreign ntry)
	Funeral Director		608-68-8669  Usual Residence of Decedent	03/14/	19, Year 194	4 Phil	ippines				
	land ow			0c. City, Town	or Loca	ation					10d. Inside City Limits
:	Mary	ţ	MD St. Mary's	Lexingt	ton	Park					1∭XYes 2□No
	or 28	Director	10e. Street and Number			10f. Zip Code				citizen of What Cou	ntry?
	23a		21512 Rominger Ct.				0653			lippines	
2	be filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23a or 28a-f show event, the hodical Evertire, must be notified a	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	er in U.S.		as Decedent of H Yes, specify Cuba □Yes 2፟ <mark>X</mark> No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	)-	14. Race - Ameri Black, White, Specify: Phi	etc.
5	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give k.	ent's Usual Occup- ind of work done o	during most of work	ring	16b.	Kind of Business/Ir	ndustry
7	vithin in i	mp	Elementary/Secondary (0-12)  College (1-4or 5+)		`life. Di ne	O NOT use retired	) -		No	one	
7	iled w Hygie ther t		17. Father's Name (First, Middle, Last)	1 110	nie		18. Mother's Nam	e (First, Middle			
	e d ala	To Be	Pedro Graneta				Felomena	a Sawi			
7 A	d 2 should be th and Mental 7 is marked of traumatic ev	ř	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City	or Town, State, Z	ip Code)
2	ゴルトサー		Mahalia Sangalang/Daughter					exingto		ark, MD 2	
U	jes 1 and of Healt if item 2 or other		20a. Method of Disposition 1 ፟ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of cemeters	Dispos y, crema	tion (Name of atory or other plac	ee)	Date		Location - City or J 1 Jose C1	-
	t. Pages tment of tant; If it ijury or o		4 ☐ Donation 5 ☐ Other (Specify)	Eterna				5/2009		eva Ecija	
ם פ	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Libersee							ineral Se ings, MD	
			23a. Pa 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do n							Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition								Onset and Death
1	/Medical Examiner		resulting in death)  Due to (or as a continuous)		of):						
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. PIELMON Due to (or as a condition)		of).					-	
	nsit	nine	Cause (Disease or injury	consequence	,						
2	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a	consequence o	of):						
0100	ite be iysicia ne bur	edical	d						_		
5	ntifica ng ph	Med	IE EEMALE.			****		_	-		-
0.00	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death, within 24 hours after death. To the Funnaral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	hysician/M	IF FEMALE:   23b. Was decedent pregnant   1								very Day Year
Ľ	res that t signed by be detac	Д	Part II. Other significant conditions contributing to death but	not resulting in	the un	derlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute to	the cause of death?
ה ה	quires en sigr uld be	ed by						1 🗆	Yes	2 <b>X</b> No 3□ Pr	obably 4 🗆 Unknown
חברו	ding Physician: The law requii h. After this certificate has been s funeral director, page 2 should	Completed						_ per	opsy ormed	prior to o	topsy findings available completion of cause of
0	ian: ] rtifica ttor, p	a)	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes th (Check only		10103	
<b>&gt;</b>	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatien:	t 2 ☐ ER/Ou		<del></del>	4 Li Nursing II	ome 5 Res	sidence	6 ☐ Other (Spec	cify)
) =	ing Pl		27. Manner of Death 1X Natural 5 □ Pending 28a. Date of Injury (Month, Day,		Time of njury	28c. Injur Wor		28d. Describe	how in	jury occurred	
2	ttend death. tor: / the fi	icati	2 Accident investigation 3 Suicide 6 Could not be	At home for	rm etro		Yes 2 □ No	28f Location	/Street	and Number or Ru	ural Boute Number
2	Il or Attenc after death Director: d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injure building, etc.	(Specify)	iii, 30c	et, lactory, office		City or To	wn, St	ate)	
	To the Hospital o within 24 hours aff To the Funeral Di completely filled in	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of and manner state and manner state	examination an	e, death	occurred at the ti estigation, in my o	me, date and place opinion, death occu	e, and due to thurred at the time	e cause e, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	o the vithin o the	Med	29b. Signature and title of certifier			29c. Licens	se number		29d.	Date signed (Monta	h, Day, Year)
	. ,,,		I ( MA IN WA)	UD		MEOO4	47374 (FL	)	A	VGUST	12,2009
	12		30. Name and address of person who completed cause of dea	ath (Item 23a) (	(Type, F	Print)				CAL CENT	,
1	( ) \			ISNR			BETHESDA				
	Sta Registr		31. Date-filed (Month, Day, Year)  AUG 1 4 2009  32. Registrar		1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\mathtt{p}^{\mathsf{M}}$ August 2009 2:00 C. Garcia Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☑ M 2 ☐ F 29, 1928 Florida 263-40-8559 April Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Invited Eventine in ust be notified at 1 ☐ Yes 2 🔀 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12700 Watertown Court 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates:1953-64 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked ot Aurelio Fernandez Garcia Mercedes Gonzalez 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a.
Important: If Item 27 is: / Daughter Susan Mori 20505 Dubois Court; Montgomery Village, MD 20886 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Crematory: 8/14/2009 | Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Simple Tribute 1040 Rockville Pike. Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus. Final disease or condition resulting in death) **Physician** Renal failure /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ MRSA Septicemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ∐Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical pletely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

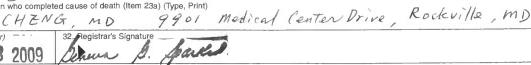
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31. Date filed (Month, Day, Year)



M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0065505

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2, Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 AUGUST 6, 1205 AM **Physician** EURITH FLUHARTY HARPER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 11 3 4, 1926 Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 □ M 2XXF 83 218-20-9078 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State r than "natural", or items 23a or 28a-f show 1 □Yes ZXNo ST. MICHAELS Director TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21663 306 CLEVELAND RD. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 \( \subseteq Yes \) Black, White, etc 11. Marital Status WHITE 1 ☐ Yes XXNo □ Never Married 2 □ Married Specify Specify If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Widowed 4 □ Divorced Completed by 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME marked other than HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORENE A. TRAX 2 should be finance and Mental F GEORGE W. FLUHARTY, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If item 27 Is many injury or other traum 17541 ORIDE RD. FT. MYERS, FL 33967 GRANDSON JAMES A. HARPER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XXurial 2 Cremation 3 Removal from State SPRING HILL CEMETERY 8-10-2009 EASTON, MD 4 □ Donation 5 □ Other (Specify) FETCOWS Add HELFENBEIN & NEWNAM FUNERAL HOE, P.A. 21. Signature of Funeral Service Livenses 200 S. HARRISON ST. EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part. Enter the disease or complications that caused the death. Do not enter to mode of dying, such as cardiac or respiratory shock, or heart failure vist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue in (or as a con a quence of): Due to (or a) a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as th 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 TEctopic pregnancy Month Day Year 5 Other (specify) 2 No P.0. sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 1 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) or Attending Physician: Be ( 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manuar of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the fur 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Mont) 29b. Signature and title of certifie TLS son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per 10 Easton, Mn 501 Outchmans illiam 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Ma	ryland / Dep Ce	rtificate of			eg. No.	27523		
	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month 08-10-		3. Time of Death		
	/Medic	al .	EARL R. HYMAN			4h Cihi Toum	or Location of Death	08-10-	-2009 4c. County of Dea	4:25 PM		
	Examin	er	4a. Facility Name (If not institution, give si CALVERT MEMORIAL H				Frederick		Calvert			
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day)		rthplace (State or Foreign Country)		
	Director		030-12-7709	M 2 F	91 Yrs.	Months Days	Hours Min.	03-07-	1918	IN		
	how lat	. [	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 X Yes 2 ☐ No		
	Ba-f s	Director	Maryland Calvert Huntingtown						10 - 011 118/h			
	with that a or 24	Dire	10e. Street and Number 3605 Foxglove Drive			10f. Zip Code 20639			10g. Citizen of What C USA	country?		
တ	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. A other than "natural", or Items 23a or 28a-f show do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funera	11. Marital Status 1 Never Married 2 Married	2. Was Decedent E Armed Forces? 1 TYYes 2 Notes	ver in U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Specific:	ite, etc.		
003	ural",	d by	3 Widowed 4 Divorced	Year or Dates:		edent's Usual Occu			B1	ack		
Maryland 21215-0036	in 72 n "nat Medica	Completed	15. Decedent's Educ (Specify only highest grade	completed) College (1-4or 5-	(Giv	re kind of work done DO NOT use retire	during most of worked)	ing				
212	filed within Hygiene. ther than " ent, the Med	등		4	<u></u>	Salesma			Private I	ndustry		
ind	ould be filed Mental Hygis arked other atic event, tl	Be	17. Father's Name (First, Middle, Last) Earl Hyman				18. Mother's Name	•	Maiden Surname)			
Z	nd 2 should by Ith and Menta 27 is marked 27 is marked 1 tranmatic ev	ဥ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Ma	ling Address (Stree	1		er, City or Town, State	, Zip Code)		
	1 and 2 s Health ar em 27 is other trau		Nikki McKinney/daug	hter		Foxglove position (Name of the matory or other place)		ntingto	wn, MD 206			
Baltimore,	8 4 4 5		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	20c. Location - City of Suitland,								
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License  May 74edgw	ian Mo	22. Name and Addr Cedar Hil		PA Ave.	, Suitland	1, MD 20746			
r	A		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.									
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute	Myoca	dicu i	nfaucto	en.				
	ificate be executed a physician and street transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of):	hic Ca	nelio vo	scular.	disease			
P.O. Box 6	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of o Month	delivery Day Year						
	uires that i signed by Id be detai	by	Part II. Other significant conditions cor		t not resulting in the	underlying cause g	iven in Part I.		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vinknown			
SCO	aw requir s been si 2 should t	olete	Acute Re	ncel	Freilw	Le		24a. Was	an 24b. Were	autopsy findings available to completion of cause of		
or Vital Records,		Completed	Peripheral		lan d	iteace		perfo	rmed?// death	i? es 2□No		
ita	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	th Check onl o	nne			
۲ ۷	di is	은	1 Yes 2 No		nt 2 ER/Outpat	ICIN OLI DOX			dence 6 □Other (S	pecify)		
	ding P. After t	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		/ W	ury at ork? □ Yes 2 □ No	28d. Describe i	how injury occurred			
Division	Il or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju- building, etc	Iry - At home, farm, c. (Specify)			28f. Location (8 City or Tov	Street and Number or wn, State)	Rural Route Number,		
_	bours hours neral	Medical Co	29a. Certifier 1 Certifying Physical Certifier 2 Medical Exami	siclan: To the best oner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manner date and place, and	r as stated. due to the cause(s)		
	To the Ho within 24 To the Fu	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Mo			
	Δ		· ceya	-0-6	mac	$\hat{\mathcal{D}}$	5065	2		- 2009		
-	3		30. Name and address of person who co		eath (Item 23a) (Typ	e, Print) GY	AN.C	- Aur	RANA	2 000		
F	St	ate	31. Date filed (Month, Day, Year)		ar's Signature	, read	, · · · · · · · · · · · · · · · · · · ·	~ cure	11112	13/		

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State of Mary Registrar	•	artment of Health and rtificate of Death		giene Reg. No. 🤈 [	100	27521				
Physic /Medi		Decedent's Name (First, Middle, Last)  Jenny Sang	g Han		2. Date of Dea Month <b>August</b>	Day 08	Year 2009	3. Time of Death 9:00 pm				
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County	of Death					
		9014 Rhode Island Avenue, Apt. 30	)3	College Park		Princ	e Georg	e's				
Funeral Director		5. Social Security Number 214-80-7763 6. Sex 1 ☐ M 2  F 7. Age (In	74 Yrs. last birthday)	If Under 1 Year If Under 24 Hours N	lin. 8. Date of Birt (Month, Da) November	h y, Year)	9. Birthpla Countr	ce (State or Foreign y) h Korea				
laryland show	or		c. City, Town or Lo			10d. Inside City Limits 1						
he M	Director	Maryland Prince George's		College Par		10g. Citizen of What Country?						
with		10e. Street and Number		10f. Zip Code	ļ	rug. Citizen of						
eath	era	9014 Rhode Island Avenue, Apt. 30  11. Marital Status 12. Was Decedent Ever		Was Decedent of Hispania Origina	(Specify Voc or No.	14 Pag	U.S.A					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Modical Examination untitled at anothe.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 ☑ No <i>Specify:</i>	erto Rican, etc.)	Bla	ck, White, et					
2 hou	ted	15. Decedent's Education		dent's Usual Occupation		16b. Kind of B						
215-	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of a DO NOT use retired)	working							
Z127 d within giene. er than "	mo.	4		Crafter		Mar	nufactu	ring				
Maryland 2 d 2 should be filed ith and Mental Hygi T7 is marked other traumatic event, in	To Be C	17. Father's Name (First, Middle, Last) Ukn		18. Mother's N	Name (First, Middle,	Maiden Surnar	<sup>ne)</sup> Ukn					
aryla 2 should and Mer is marke	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Number or	Rural Route Numbe	er, City or Town	, State, Zip (	Code)				
and 2 and 2 tealth a m 27 ls		Victor Han - Son	2	1777 Lady Slipper S	quare, Ashbu	ırn, Virg	inia 20	L47				
<b>Baltimore</b> , oermit. Pages 1 ar Department of Heal Important: If item any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State		sition (Name of natory or other place)	Date	20c. Location						
It morr it. Pages in intrant. If ite injury or of		4 □ Donation 5 □ Other (Specify)			3/17/2009	Brentwo	ood, Mar	yland				
Dail permit. Depart Imports any Injo		21. Signature of Euneral Service Licensee	H	2. Name and Address of Facility ines-Rinaldi Funera 1800 New Hampshire			e. Marv	land 20904				
		23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					,	Approximate nterval Between				
Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)  a. Autocomparison of the condition of the cause of the ca										
rificate be executed g physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last  c. Huperoca consequence of):										
ificate g phy s the	edical	d										
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown		1	ate of deliver onth E	/ ay Year						
ires that signed by	ρĺ	Part II. Other significant conditions contributing to death but not Mening to ma	t resulting in the ur	nderlying cause given in Part I.	23e. Did to	23e. Did tobacco use contribute to the cause of de						
w require been significations	etec	000000000000000000000000000000000000000			' _ '	es 2 No	3	oly 4 Unknown				
sician: The law requires to certificate has been signe rector, page 2 should be d	Completed	Color Cancer			24a. Was a autop perfor 1 □ Yes	rmed?	Were autops prior to com death? 1 \sum Yes 2	sy findings available pletion of cause of No				
sician: Ti certificate irector, pa	Be	25. Was case referred to medical examiner?		26. Place of I	Death (Check only or	ne)						
Physical this call dire	은	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatien		g Home 5 Resid	lence 6 □Otl	ner (Specify)					
ding F h. After funera	ü	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Yea	ar) 28b. Time of Injury	Work?	28d. Describe h	ow injury occur	red					
lor Attending Physafter death.  Director: After this lin by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - building, etc. (S)	At home, farm, stre pecify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (S City or Tow	Street and Numl	ber or Rural	Route Number,				
_ o # 15 15	ᄩ		City or Town, State)  ce, and due to the cause(s) and manner as stated.									
ne Hospital or n 24 hours afte ne Funeral Dir oletely filled in	dical Certi	29a. Certifier (Check only one)  1 ertifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death mination and/or inv	n occurred at the time, date and pl vestigation, in my opinion, death o	ccurred at the time,	date and place,	and due to t	ted. he cause(s)				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	Medical Cert	Medical Examiner: On the basis of examiner	y knowledge, death mination and/or inv	n occurred at the time, date and pl vestigation, in my opinion, death o 29c. License number	ccurred at the time,	date and place, 29d. Date signe	and due to t	he cause(s)				
To the Hospital of within 24 hours aff To the Funeral Discompletely filled in	edical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death mination and/or inv	vestigation, in my opinion, death o	ccurred at the time,	date and place, 29d. Date signe	and due to t	he cause(s)				
To the Hospital of within 24 hours aff	Medical	(check only one)  2   Medical Examiner: On the basis of examiner and manner stated.  29b. Signature and title of certifier	(Item 23a) (Type, F	29c. License number  D 14905  Print)	ccurred at the time,	date and place,	and due to to ded (Month, D	he cause(s)				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Gerald Andrew Hitch 08 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE EVINDALE 8. Date of Birth (Month, Day, Year) April 5, 1956 Washington D.C. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Days 1**X** M 2□ F 214-68-9177 53 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Charles Indian Head Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20640 U.S.A. 408 Bland Drive 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner **Employed** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Hitch, Sr. Smith Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 408 Bland Drive, Indian Head, Md. 20640 Wanda J. Hitch 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Charles Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Indian Head, Maryland 22 Name and Address of Facility Williams Funeral Home, P.A. 21. Signature of Funeral Service 20640 23a. Part1. Enter y e di lease, or shock, or heart faiure. List Approximate Interval Between Onset and Death Immediate Caus Un al disease or condition resulting in death)

**Physician** /Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

IF FEMALE:

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

**Funeral Director** 

ģ

Completed

Be

10a. State

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical ğ Completed Be ( Certification: To Medical

Division or Vital Records, P.O. Box 68760,

complications that caused he death. Do not enter the mode of dying, such as cardiac or respirator	
only one cause on each line.	y arrest,
CORONARY ARTERY DISER	755
Due to (or as a consequence of):	
b. Tue to (or as a consequence of):	
c Due to (or as a consequence of):	
d	
23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of deliver

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4□Pregnant at time of death

9 Unknown

1 Yes 2 No 3 Probably 4 Unknown												
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?												
Check only one)												
5 ☐ Residence 6 ☐ Other (Specify)												

Day

Year

Month

23e. Did tobacco use contribute to the cause of death?

	26. Place of Death (Check only one)										
examiner? 1 Yes 2 14 No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	M M	c. Injury at Work?  1 □ Yes 2 □ No									
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury · At home, farm, street, factory, o building, etc. (Specify)	office 28f. Location (Street and Number or Rural Route Number City or Town, State)	e <i>r</i> ,								

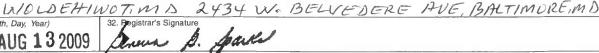
5 ☐ Other (specify)

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occur									
(Check only one)	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca and manner stated.									
29b. Signature and	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)							

DUIM It. WOLDELLIWOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DB 10 State Registrar

31. Date filed (Month, Day, Year) AUG 132009



#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** EVELVN 2009 12.09 AM AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deat Examiner WASHINGTON MEDICAL GLEN BURNIE ANNE BALTIMOKE HRUNDEL 下りLEY 7. Age (In yrs. last birthday) If Under 24 H 8. Date of Birth (Month, Day, Year) Feb. 26, 1959 Birthplace (State or Foreign Country) Funeral 1 M 2 F Months Days Hours Min. 218-98-2901 Yrs Feb. Director Uganda Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at M D Anne Arundel Millersville Director 1 XYes 2 No Street and Number 8163 Weyburn Rd. 10f. Zip Code 10g. Citizen of What Country? 21108 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married African American Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 1 and 2 should be filed within Health and Mental Hygiene. Prince Georges County Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Environmental Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If them 27 Is marked oil any Injury or other traumatic ever once. Moses James Ssempala Agatha Manqwe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Howard Mason /husband 8163 Weyburn Rd., Millersville, MD 21108 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/20/2009 1x Burial 2 ☐ Cremation 3 Kemoval from State Uganda Mukono 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. andré 7400 Georgia Avenue, NW, Washington DC 20012 Sho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician day disease or condition resulting in death) **Medical** Due to (or as a consequence of). xaminer NAUMO Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) the 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗆 No 1 ☐ Yes 2 KN0 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠XYes 2 🗍 No 1 Anpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760, 0 124 hours after death.

Reference of the filled in by the filled in by the filled in the filled in by the filled in t within 2 To the I

> State Registrar

Medical

(Check only one)

DRJANAKI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DEEPAK

10

00065097

BALTIMORE WASHINGTON MEDICAL CENTER

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1323 **Physician** R. Johnson Augusi Janet 12 2009 /Medical 4c. County of Death . 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 30/13bUM KICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-23-1933 Birthplace (State or Foreign Country) Social Security Number 6. Sev 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F Delaware Yrs. 222-18-4425 75 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examinar must be reditled at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 □ No Director Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 30379 Pine Street 21853 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Propane Company none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Burris John Riggins ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William H. Johnson, Jr./husband Anne, MD 21853 30379 Pine Street, Princess 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Andrews Episcopal 08/15/2009 Princess Anne, MD 4 Donation 5 Dother (Specify) ignature of Funeral Service Lice Vee 22. Name and Address of Facility Home Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 M00295 Approximate Interval Between Onset and Death 28a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical for use as the 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 9 ☐ Unknow signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 □Yes : After this certifical funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier on who completed cause of death (Item 23a) (Type, Print) 30. Name and adds 100 E. Carroll St. Wilhi Dona (as 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - State of M Registrar		ertificate of D	eath	Reg.	_ 2000	27528					
	Physicia		1. Decedent's Name (First, Middle, Last)  LETTIE PEARL	JOHNSO	N		2. Date of Death Month	Day Year	3. Time of Death					
<u>}</u>	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number,		4b. City, Town, or L	ocation of Death	8. Date of Birth (Month, Day, Ye	4c. County of Death	lace (State or Foreign					
	ס	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Somerset			0d. Inside City Limits 1 ☐ Yes 2⁄√☐ No								
	aa or 28	Il Director	10e. Street and Number 27311 Cash Corner Road		10f. Zip Code 218	17	10g.	Citizen of What Cour	itry?					
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantine must be nothed at once.	by Fur	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Armed Forces 1 Yes 2 Figure 1 Yes 2 Figure 1 Yes 2 Figure 1 Yes 3 Figure 1 Yes 4 Fig	No	B. Was Decedent of His If Yes, specify Cuban, 1 □Yes 2X No	panic Orlgin? (Spe , Mexican, Puerto F <i>Specify</i> :	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.					
Maryland 21215-0036	within 72 ho ene. than "natur he wedien	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Giv	cedent's Usual Occupative kind of work done du . DO NOT use retired)	ion ring most of workin	ng	e. Kind of Business/In Paint Brusl						
nd 2	be filed tral Hygind of other event, I	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Mai							
Maryla	12 should h and Mer 7 is marke traumatic	잍	Benjamin Freely Nelson  19a. Informant's Name/Relationship (Type. Print)  Yvonne Lawson (Daughter)	19b. Ma	iling Address <i>(Street ar</i> 25 Farm Mar	nd Number or Rura	I Route Number, C	ity or Town, State, Zip	O Code) MD 21838					
Baltimore, I	Pages 1 and 2: nent of Health a int; If item 27 is iry or other trains		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis	position (Name of ematory or other place, e Memorial Pa	) D	ate 20	c. Location - City or To	own, State					
Balti	permit. Departn Importa any inju		21. Signatur Pinedi Service Lic. 180 Robert H. Bradshaw, 12		22. Name and Address Bradshaw & 306 W. Mair	Sons Fun St C	risfield	, MD 2181						
	Physician /Medical		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition	lisease or condition										
	Examiner	L.		LAD										
·,	rificate be executed og physician and as the buriat-transit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events c.	s a consequence of):	e of):									
68760,	physicia the buri	edical	d											
O. Box	death certi e attending d for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 menths?  1 □ Yes 2 □ No 9 □ Unknown			23d. Date of deliving Month	very Day Year							
rds, P.	law requires that the de as been signed by the a 2 should be detached t	þ	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause give	n in Part I.		cco use contribute to	the cause of death?					
Vital Records,	The ate h	Completed					24a. Was an autopsy performe 1 □ Yes 2 €	prior to co death?	opsy findings available ompletion of cause of					
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpa	itient 2 ☐ ER/Outpat	Otho	. /	(Check only one)	ce 6 ☐ Other (Spec	i(r/)					
of	ding h. After funer	tion: To	27. Manuer of Death 1 Natural 5 Pending (Month, D	njury 28b. Time	e of 28c. Injury Work		28d. Describe how							
Division	il or Attending after death. I Director: After d in by the funer	Certification:	3 Suicide 6 Could not be 28e. Place of I	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,					
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best and manner and manner	of examination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	and due to the car red at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)					
	To the Comp	M	29b. Signature and title of certifier		29c. License	094	8	d. Date signed (Month	, Day, Year)					
			30. Name and address of person who completed cause of	f death (Item 23a) (Typ	Di VISION SY	eis saris	Airy u	1 21804						
	Sta Regist		30. Name and address of person who completed cause of the complete cause of the cause of the complete cause of the complete cause of the cause	strar's Signature	pare									

CTB 322 AM

8-12-09

Lettie P. Johnson

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 13 2009 06:46 AM August Betty Pearl Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Union Hospital of Cecil County E1kton Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 ☐ M 2 🛣 F Maryland Yrs 18,1929 80 Jan. Director 213-24-2153 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Executiver trust be notified at 1 Yes XXNo Director North East Marvland Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ United States 21901 1607 West Old Philadelphia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 6 1 ☐ Yes 2 💢 No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 9 Homemaker Own Home is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armitta Elburn William Higgins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 & Department of Health ar important: If item 27 is any injury or other trausonce. 21901 119 Edgewater Avenue, North East, Maryland Robert Jones / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Methodist Cemetery 20c. Location - City or Town, State August 17, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 North East, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or coxplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final unknown **Physician** disease or condition resulting in death) / /Medical Due to (or a a consequence of): Examiner D Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 5 ☐ Other (specify) 23e Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To

Box 68760, P.O. Division of Vital Records, After this

Baltimore, Maryland 21215-0036

1 Yes 2 □ 27. Manner of Death

29a, Certifier

(Check only one)

Medical

State Registrar

1 Natural 5 Pending 2 Accident 3 ☐ Suicide 4 Homicide

investigation 6 Could not be determined

1 mpatient Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

West man St. EllChon Hd 21921

28d. Describe how injury occurred

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 223

and manner stated.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

within 24 hours after death.

To the Funeral Director: #

Paul Michael Johnson 09-06087

Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		Re	For State			Cer	tificate o	f Death	7				Reg. N	lo		10 =	(0)
	Physician/ edical Examiner  1. Decedent's Name (First, Middle, Last) Paul Michael Johnson  Paul Michael Johnson  2. Date of Death Month Day Yea August 4, 2009												212	e of Death 23 hrs			
		4	a. Facility Name (if not institution Rt. 295 South of Rt. 4			ımber)		4b. City, To		ocation of	Death			4c. County Prince			
	F	,,	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9.												(State or Foreign		
Funera Directo		5	217-60-5415	1 X M 2	2F	5.5		Months	_	Hours	T 16-	June	27,	1954	+ Co	DC	
<b>b.</b>	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location														10d. lr	iside City Limits	
_ ow an	. الله		DC Tob. County			Toc. City,	, TOWITOI LOCE	tion.	Wa	shing	gton	-				1 X	Yes 2 No
aryland	lified at once	<u> </u>	0e. Street and Number					10f. Zip				-	10g.	Citizen of V	What Cou	intry?	
the Ma	tified		629 Galveston	Place	e SI	Ξ				0032				Unit			
h with	must be no	1 2	Marital Status     Never Married 2 M			cedent Ever in U	.S. 13. W	as Decede Yes, specif	nt of Hisp y Cuban,	anic Origir Mexican, I	n? (Spe Puerto R	cify Yes or tican, etc.)	No-		ce - Ame	rican Ind	ian, Black,
72 hours after death with the Maryland n"matural", or items 23a or 28a-f show any	r mus				Yes Give Ye	2 X No	1	Yes 2	X No	specify:				Specif	y: Bla	ack	
urs afte iural"		<u>-</u>  2	15. Decedent's Education (Spe	lor Da	tes:		16a. Decede	nt's Usual	Occupation	n (Give ki	ind of wo	ork done	16	b. Kind of	Business	/Industry	
N .		napald mon	Elementary/Secondary (0-12)	C	College (1-4 or 5+) during most o						jse retire	eu)			<b>.</b>		
1D 21215-0036 2 should be filed within 72 and Mental Hygiene. 27 is marked other than "	Medi	틸	12th				Ca	rpet		_	Name (	First, Middl	e Mair	den Surnar	Priv	ate	
15-0 filed v Hygi d otho			7. Father's Name (First, Middle John T. Joh		Sr.				'			n Hol			,		
21215 ould be fill Mental F marked	even C	o ne	9a. Informant's Name/Relations	_			19b. Maili	ng Address	(Street			ural Route I		r, City or T	own, Sta	te, Zip C	ode)
MD 2 nd 2 shou alth and 2 m 27 is r	matic	-	Gregory D. J			rother	3808	Swar	nn Rd	. Su	itla	nd, M	ld.	2074			
re, MI 1 and 2 s Health a fitem 27	r trau	- 11	20a. Method of Disposition				Place of Disp crematory or			etery,	Aı	Date ugust	2	0c. Locatio	on - City o	or Town,	State
MOF Pages ent of nt: If	or other traumatic event,	٠L	1 X Burial 2 Cremation 4 Donation 5 Other S	n 3 Re	emovai	Res	surrect	ion C	emet		11,	2009					yland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	jury o	1	22. Name and Address of Facility Stewart Funeral Hom 4001 Benning Rd. NE Washington, D														ic. 0019
	_	1	23a. Park. Enter the disease, o	Complication	M Ins that	caused the deat										App	roximate Interval
Physicia Medic		1	failure List only one cause	on each lin	e.		20		. , ,							Bet	ween Onset and Death
Examin	er		Immediate Cause (Final disease or condition resulting in death)			a consequence	of):										
			Sequentially list conditions,	b	o (or as	a consequence	of).								_		
		۱⊒	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated													_	
ted d			events resulting in death) Last	Due t d.	o (or as	a consequence	uence of):										
e execu	s the burial - transit	n/Medical	UNPENDED AMENDED														
8760, tificate be ng physici	he bur	ğ	F FEMALE: 3b. Was decedent pregnant in			s, outcome of pre				Te				23d. Date Mont	e of deliv	ery	Year
OX 687 sath certiff	ise as	cian	past 12 months?	1 4		e birth gnant at time of c		Fetal death Other (Spe		Ectopic	c pregnai	псу		I Work		Day	1001
Box 68 in death certification the attending	d for	Physicia		nknown	-	nown										A - 4b	of dooth?
o. hat the	letache	2	Part II. Other significant cond	itions cont	tributing	to death but not	resulting in th	e underlyin	g cause g	jiven in Pa	art I.						ause of death? 4 Unknown
S, D urires t	ld be	Completed by											Vas an	-	4b. Were	autopsy	findings available
Vital Records hysician: The law requi this certificate has been	2 shou	Bet	<del></del>			<del></del>						p	utopsy erform	/ ned?	death	?	etion of cause of
Rec The la	page	5									701		'es 2	No	1 🗸	Yes	2 No
tal   cian: certifi	ector,	B B	25. Was case referred to medic examiner?	al Hospi	tal: ,	]	ER/Outpati	n 2	26.Place	of Death Other		g Home 5	R	esidence	6 <b>✓</b> Ot	her: Sce	ne
of Vi Physi er this	eral dir	위	1 ✓ Yes 2 No 27. Manner of Death		_ '	Inpatient 2 te of Injury	28b. Time			ry at Work	k?	28d. Desc	ribe ho	w injury oc	ccurred		
On O nding rth.	e func	<u>:</u>	1 Natural 5 Per	iunig	Aug 4	ite of Injury nth, Day,Year) , 2009	2111 hrs		1 \	Yes 2 ✓	No No	Pedestri	an st	ruck by	auto		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it and refer death.  **In after death.**  **All Principles**  **	in by ti	Certification:		estigation Luld not be	28e. Pl	ace of Injury - At	home, farm, s	treet, factor	y, office b	ouilding, et		or To	un Cto	ata)			oute Number, City
Div	filled	Serr	4 Homicide det	ermined		fy) Highway						Rt. 295 S	outh c	of Rt. 450			verly, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as	cal	29a. Certifier 1 Certifying (Check only one) 2 W Medical Ex	Physician: aminer:On	To the t	est of my knowle	edge, death oo and/or invest	curred at th gation, in n	ne time, da ny opinior	ate and pla n, death oc	ace, and ccurred a	due to the at the time,	cause date a	(s) and ma nd place, a	inner as s and due to	stated. o the cau	se(s)
To the within To the	com	Medical	29b. Signature and title of certi	and	manne	r stated.				se number				29d. Date			
			ille 6		M	>			O.C.	M.E.				August	5, 200	9	
			30. Name and address of person	on who comp	oleted c	ause of death (Ite	em 23a)										
L 3			Melissa Brassell, MD		tant N	Medical Exam	niner 11	Penn S	Street, E	Baltimor	e, MD	21201					
		ate	31. Date filed (Month, Day, Yea	1 her	32.	Registrary Sign.	ature	,									

		1	For State	Stat	e of Ma	aryland /		rtment of H tificate of L	ealth and M D <i>eath</i>		giene Reg. No	009	27531
		ľ	Registrar  1. Decedent's Name (First, Middle,	Last)				timouto or z		2. Date of Dea	ıth		3. Time of Death
Physi		ı	Joe Cannon Je							Month August	8, 2	009 <sup>Year</sup>	7:00 A M
/Med	dical niner		4a. Facility Name (If not institution,		nd number)			4b. City, Town, or	Location of Death			ounty of Death	
			Asbury Solomons					Solomon		0 D-14 Dint		Calver	
Funera Directo			5. Social Security Number 253-12-9510	6. Sex 1 🔼 M 2 ☐		e (In yrs. last I 85	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 10/06/	1923	Geor	nplace (State or Foreign Intry) gia
/land ow		-	Usual Residence of Decedent 10a. State 10b. County			10c. City, To	wn or Lo	cation					10d. Inside City Limits
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th the	je		10e. Street and Number					10f. Zip Code			10g. Citize	n of What Cou	untry?
ath wi	2	5	11740 Asbury Ci				140.1	N D	20688	asifu Van or No	14	USA . Race - Amer	rican Indian
<b>Baltimore,</b> Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment was the motified at	by Euperal Director	oy - call	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 🛣	Decedent E ed Forces? Yes 2 \( \subseteq \) s, Give r or Dates:		541	was Decement of A fYes, specify Cuba I □Yes 2 🕱 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)		Black, White	, etc.
L15-UU36 thin 72 hours aff e. an "natural", or Medical Exami	Completed	Jeren	15. Decedent's (Specify only highest	s Education t grade compl	eted)		6a. Deced (Give life. L	dent's Usual Occup kind of work done o OO NOT use retired	ation during most of work ()	ing	16b. Kind	of Business/I	ndustry
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Viand ould be file Mental Hy arked oth	1		Henry Smith Jennings Lillian  19a, Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Ro										
Mar nd 2 sho alth and 27 is m			19a. Informant's Name/Relationsh Joyce Jenning			1	9b. Mailir 1174	og Address (Street of Asbury	and Number or Rur Circle #	1317, S	er, City or 1 olomo	ns, MD	20688
Saltimore, bermit, Pages 1 ar Department of Hea mportant: If item i			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp		from State	ceme	etery, cren	sition (Name of natory or other place e Cremate		Date /2009		ition-City or	
<b>Balti</b> permit. F Departm Importal	ouce.		21. Signature of Funeral Service L		Pert		22	. Name and Addres	ss of Facility Jo	hn M. Ť			ral Home, In , mD 21401
		$\dagger$	23a. Part 1. Enter the disease, or o	complications	that caused	I the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
Physicia	ın		shock, or heart failure. List of Immediate Cause (Final disease or condition	only one caus	e on each iir		ind	to	Thrive	0		-	Onset and Death
/Medica	al		resulting in death)	a	ue to (or as	a consequence	ce of):						
Examine	■.		Sequentially list conditions,	b		-		15'A					
ted			Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Lest		Due to (or as a consequence of):								
58760, ficate be executed physician and s the burial-transit		ũΙ	that initiated events resulting in death) Last	a consequence	ce of):								
8760 cate be c cate be c cate be c	100	Z Z	1	d									
Box ( sath certi attending for use a	ion/Ma	Sicial living	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Ĺ 4 Ľ	Live birth	of pregnancy 2 ☐ Fetal de It time of deat	ath 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23	d. Date of del Month	livery Day Year
that the ed by detac	į		Part II. Other significant conditio	ns contributin	g to death b	ut not resultin	g in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	e contribute to	the cause of death?
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M M M		analdillo	//	810 51	txte		Cyn	ical		24a. Was auto perfo		prior to death?	utopsy findings available completion of cause of
		υ	25. Was case referred to medical examiner?						26. Place of Dea				
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On Of ding Ph h. After th funeral		5	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	g	. Date of Inju (Month, Da		b. Time o Injury	Wor	k?	28d. Describe	how injury	occurred	
Sitten theat the		Certification.	2 Accident investig	and he	Place of Inj	jury - At home	, farm, str	reet, factory, office	Yes 2□No	28f. Location ( City or To	(Street and	Number or Ri	ural Route Number,
Div tal or s afte al Dire	1	La l	4 ☐ Homicide determine	1						11			
DIVI the Hospital or Al hin 24 hours after of the Funeral Direc mpletely filled in by	1	Medical	29a. Certifier  (Check only one)  1 ★ Certifyin  2 ★ Medical	Examiner: O	To the best n the basis o d manner st	of examination	dge, deat n and/or ir	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to the irred at the time	cause(s) , date and p	and manner a place, and due	s stated. e to the cause(s)
To the within 2		ME	29b. Signature and title of certifier	1/	/	Red	71	29c. Licens			29d. Date	signed (Mont	th, Day, Year)
			7 / )	who committee	od pavies of o	death (Item of	Ra) /Time		005224			0/10	MD
CHI IN	1		John Barth M.D						ding 110	Hospita	al Rd.	Princ	
Regi	State istra							park	<u></u>				
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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician  $P^{M}$ Jackson 06, 2009 9:46 June Bass Auq. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) (In yrs. last birthday) 82 Yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age Date of Birth (Month, Day) **Funeral** Months Days Hours 241-40-5193 June 05,1927 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modeal Examinar must be notified 34 once. 1 ☐ Yes 2 ☑ No Gambrills Director MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21054 USA 2605 Chapel Lake Lane, Apt. 303 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Principal Education 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Eugenia Marshall Raymond Andrew Bass ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1715 Mayfair Place Crofton, MD 21114 Jacquelyn Jackson/ Daughter August 10, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. 2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Lice ye Barrancodessons, P.A. Severna Park Funeral Home Gov. Ritchie Hwy, Severna Park, MD 21146 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Par 1. Enter the disease, or shock, or heart failure. List mmediate Cause (Final Physician mmediate Ventricular lachycardia diseas or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Muncavdia

Due to (or as a consequence of): burial-trar physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tille of certifier wunes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George B. Cavanagh Mel 20716 Mitchellyi Registrar's Signature Year) 11 State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2009 0:05 AM ugust ance /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maple ambridge Dorchester Koad 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. **Funeral** 1 □ M 2 🖫 F Months Days 1936 Marylana **Director** Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at 1 ☐ Yes 2 TP No Director orchester ambrid permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturally any injury or other traumatic exertions." 10f. Zip Code-10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garment Indust Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) : Fford Dam Road MD.21613 1es Maple ambridge 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cambridge cktown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address / f Facility HENRY 510 W washington 0,21613 10 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner 2/0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day ed by the a detached fr 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has N autopsy page, The performed? 1 ☐ Yes 2 ☐ No 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 2 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 🗌 Yes 2 🗆 No within 24 hours after death

To the Funeral Director: 
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar LAHB

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:00 AMM 2009 12, Vance B. King August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner North East Cecil 59 Kirks Mill Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2□ F March 28, 1937 Virginia 215-32-3849 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 23a or 28a-f show N 1 ☐ Yes 2XXXNo event, the Medical Evan from roust be notified Director Ceci1 North East Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21901 United States Funeral 59 Kirks Mill Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2X No Specify: White ò 3 X Widowed 4 □ Divorced natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Automotive 9 Assembler and Mental Hygid Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Charlotte Elizabeth Groseclose ပ Owen Repass King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 16 Blake Drive, Rising Sun, Maryland 21911 Ramonia S. King/Daughter-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date August 15 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nottingham, 2009 Freemont Cemetery Pennsylvania 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Li 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer MAROWN /Medical Due to (or as to nsequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, the death certificate be Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe 1 ☐ Yes . No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 ☐ Nursing Home S ☐ Residence 6 ☐ Other (Specify) 2. ₩o 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aft e Funeral Di letely filled in \* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the l within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Vince ami 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Month **Physician** 7:55 P M August Ja Kim /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 18520 Cherry Laurel Lane Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 ☐ XF Director Dec 25, 1944 Korea 213-02-4702 64 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with innert of Health and Mental Hygiene.
smt. If item 27 Is marked other than "natural", or items 23a or Korea 20879 18520 Cherry Laurel Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deli Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oak Sil Kim Soo Ho Kim ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is,
any Injury or other trau. 18520 Cherry Laurel Lane Gaithersburg, MD 20879 Sang Chul Kim/husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey Crematory 08/10/09 Woodbine, MD 4 Donation 5 Dother (Specify) 21. Signatura f Funeral Service I Going Modes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 □Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending n 24 hours after death.

Re Funeral Director: After the further of the further 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi

State Registrar Matthew McAndrew, M.D. 1355 Piccard Dr.

31. Date filed (Month, Day, Year)
AUG 12 2009

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

#100 Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year M 2009 INDEMON. MATHA ANN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last b Months Days 191-40-7576 59 Yrs -12-1949 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☑ No MD NANTICOKE WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21840 20185 NANTICOKE 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) COPPENHAVER DOAN M. UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) hoiss nanthoke ad hanthoke, ind yibyo MICHAEL IN DEMON 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date SALISBUDY MD SAHISBURY (hemisticiza 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Add 8 of Facility 21. Signature of Funeral Service License MESSICK FUNEREL HOME TO BOX 61 BIVALVE, MD 3/814 MOYL 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MULTIPLE SCLEROSIS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Division of Vital Records, P.O. Box 68760,

**Physician** 

Examiner

**Funeral** 

Director

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Funeral

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Certification: To

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examinar must be notified at

permit. Page:
Department of
Important: If
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**Physician** 

/Medical

Examiner

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certificate director.

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Baltimore, Maryland 21215-0036

Maryland

/Medical

Hospital or Attending Physiclan: The law requires that the death certificate be executed 124 hours after death.

Funeral Director: A pletely filled in by the form completely To the l

					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No								
25. Was case referred to me	dical	26. Place of Death (Check only one)												
examiner? 1XYes 2 □ No	Ho	lospital: 1 🗆 Inpatient 2 🔀	ER/Outpatient 3 □ □	lome 5 ☐ Residence 6	ne 5 Residence 6 Other (Specify)									
Z LI ACCIDENT	vestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred								
	ould not be etermined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, facto y)	ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a Certifier 1 Cert	tifylna Phys	sician: To the best of my kno	wiedge, death occurre	d at the time, date and place	and due to the cause(s)	and manner as stated.								

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie

29c. License number D 48098 29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201, HALL HIGHWAY, CRISFIELD, MD KARUMBUNATHAN Dr. VIJAY

State Registrar 31. Date filed (Month, Day, Year) AUG 13 200



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2303 PM 2009 0 MATTHEWS LEE VIRGINIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1(0M 2311512 8. Date of Birth (Month, Day, APRIL 6, 9. Birthplace Country) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Min. 1 ☐ M 2 ☐ F VA 84 Director 228-24-2171 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County ru orner than "natural", or items 23a or 28a-f show event, it is We Month Event as must be notified at 10a. State 1 ☑Yes 2 ☐ No Director ACCOMACK ATLANTIC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 23303 10264 ATLANTIC ROAD Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ∐Yes 2 🗰 No Specify: Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked t any injury or other traumatic ewoods. GEORGE WASHINGTON MARSHALL ELIZABETH HALL ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) TOMMY LEE CHANCE PO BOX 243, OAK HALL, VA 23416 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EVANS CEMETERY 8/13/2009 SAXIS, VA 22. Name and Address of Facility
THORNTON FUNERAL HOME CARL U. THORNTON 24183 CHADBOURNE ST. - PARKSLEY, VA 23421 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) septic shak **Physician** /Medical Due to (or as a consequence of): Examiner 250 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi) Examine requires that the death certificate be executed burial-transit L and to (or as a consequence of) physician Box 68760 Physician/Medical the as attending for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 4 🗗 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No has 1 ☐ Yes 2 ☐ No certificate Division of Vital e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2☐ Medical Examiner: 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:30 p.M Maddox Waters 2009 Virginia Addie August /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Nursing Home 7. Age (In yrs. last birthday) Worcester Hartley Hall 5. Social Security Number 6 Pocomoke If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 □ M 2 🖫 F Yrs. Kingston, Md. Director 219-14-3898 NOV 12,1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28~ 4 - 1 any lighty or other traumatic event, the Market - 1 once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Station Marion Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Hwy. 21838 Crisfield 6626 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry School Elementary/Secondary (0-12) College (1-4or 5+) Somerset County Bd. of. Ed. Diet itian 12 th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nettie Burnette Waters Omar Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crisfield Huy. Marion Station, md 21838 6626 Elton P. Maddox Sr. - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State moder family Cemetery 8/15/09 Kingston, mc 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee 5- Wand Hamplen ave, Princess Anne, md 21853 30639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER'S 1) EMENTIA Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, example to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by AICII) EN CEREBROVASUILAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed? 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death.

To the Funeral Director; / completely filled in by the f 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

State

To the h

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAL, MI 1604 MARKET R SHARAD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

29c. License number

D 00 62172

POCOMORE Gry MI)

29d. Date signed (Month, Day, Year)

2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar			of Maryla	and /	-			lealth D <i>eath</i>	and N	/lental Hy	/giene Reg. No.	, since the same	American company com	103
0	Physicia /Medic	an	1. Decedent's Name (First, Midd ELVA JOAN MO										2. Date of Do Month AUGUS		2009 <sup>Year</sup>	3. Time of 1:10	Death M
9	Examin		4a. Facility Name (If not institution  DORCHESTER GEN	ERAI	HOSP				CAMI	BRID				D	County of Death		
	Funeral Director		5. Social Security Number 217–28–4304	6. Sex	M 2 <b>X</b> F	7. Age (In y	75. last l	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D OCTOBE	rth R 18,	9. Birthy Coul	ntry) MARYLA	r Foreign
de	laryland show	JO.	Usual Residence of Decedent  10a. State 10b. Count  MARYLAND TA	LBOI	1	10c.		wn or Loc							1	0d. Inside Cit	,
8	with the Marylar a or 28a-f show be notified at	Direct	10e. Street and Number 21655 WILLEY R		•		7.1	LGHM	10f. Zip	Code <b>2167</b>				10g. Citi	zen of What Coul	ntry?	
036 E/U	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinations out by notified at	by Fu	11. Marital Status  1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried	12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi Year or D	edent Ever in orces? 2 <b>X</b> No ive oates:	U.S.			lent of Hi			pecify Yes or N Rican, etc.)		14. Race - Americ Black, White, Specify: WH	etc.	
215-00	within 72 ho liene. • than "natur The Medical.	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Educ est grade	cation completed) College (		16	(Give l life. D		k done a e retired	ation luring mos )	t of work	sing	1	nd of Business/In		- 1
Morc Iland 2	2 should be filed within and Mental Hygiene. is marked other than aumatic event, Inc. M.	To Be Co	17. Father's Name (First, Middle LISTON WOODR					OP	ERAT	)K			e (First, Middle	e, Maiden	MUNICAT] Surname)	LONS	
Mary	1 and 2 should Health and Men em 27 is marke other traumatic		19a. Informant's Name/Relation				19		-						r Town, State, Zij	Code)	
Baltimore,	permit. Pages 1 ar Department of Hes Important: If item any injury or othe once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (  21. Signature of Funeral Service	Specify)	-			JOHN 1 22. FE	Name an	METE d Addres S , H	RY 0 s of Facilit ELFEN	8/07 BEIN		TII I MAN	cation - City or To LGHMAN, I	MARYLAN HOME, I	P.A.
0	Physician /Medical Examiner		23a. Part 1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	r complie t only on	cations that ce cause on e	Athe	eath. D	o not ente	or the mod	e of dying	g, such as	son cardiac	or respiratory	arrest,	e	21601 Approximate Interval Bett Onset and D	veen
8760,	ate be executed hysician and the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			(or as a cons	02	the	èn è	d S H Re	tegl east ido	f	enel p audio	leac	ese		
.O. Box 68	Attending Physician: The law requires that the death certific r death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 MRNo 9 □ Unknown	23	1 Live	tcome of preg birth 2  Fe nant at time on	etal dea		Ectopic po		′			2	23d. Date of deliv Month	•	⁄ear
rds, P	w requires that the d s been signed by the should be detached	þ	Part II. Other significant condit	ons con	tributing to d	eath but not r	esulting	in the un	derlying ca	ause give	en in Part I			tobacco u Yes 2[	ise contribute to t ☐ No 3 Pro	he cause of d bably 4 □ L	
l Reco	ician: The law rec certificate has bee ector, page 2 shou	Completed	C	P	D_								24a. Was		24b. Were auto	impletion of ca	available ause of
Vita	ysician: is certifica director, p	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No		ospital: 1ГХ	Inpatient 2	□ EB/0	Outpatient	3 DO	A Othe	۲۰		h (Check only	one)	3 ☐ Other (Speci		
Division of Vital Records, P.O	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 风 Natural 5 □ Pendi	gation not be	28a. Date (Mon	of Injury hth, Day, Year) of Injury - At ing, etc. (Spe	28b	. Time of Injury	M 2	Bc. Injury Work 1 □ \			28d. Describe	how injur	y occurred  d Number or Run		ber,
_	e Hospita 124 hours e Funeral		29a. Certifier 1 ertifyi (Check only 2 Medica	ng Phys Examin	ier: On the b	e best of my k pasis of exami ner stated.	nowled ination :	ge, death and/or inv	occurred estigation,	at the tim in my op	ne, date ar pinion, dea	nd place, ath occur	, and due to the red at the time	e cause(s) , date and	and manner as it place, and due t	stated. o the cause(s	)
	TLS Comp	Me -	29b. Signature and title of certifie	er -	, 1	10	-		290	License	number 3	35	9	29d. Dat	e signed (Month,	Day, Year)	-
	Stat	4	30. Name and address of person  MAHBUG 31. Date filed (Month, Day, Year,	A	AUE 32. A	se of death (It	2,	5 O	Print)	3y	en :	Str	ect, c	and	beidge	, MD	-2161
	Registra	ır	AUG 07	2000	<b>A</b>		4	ha	1								ļ

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**Physician** /Medical Examiner

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Vital Records,

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Baltimore, Maryland 21215-0036

burial-tran been signed by the salvould be detached within 24 hours after use...

To the Funeral Director: Af

certificate

Hospital or Attending

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Medical Certification:

28d. Describe how injury occurred

10:00<sup>p</sup> M 1 ☐ Yes 2 ☐ No 7/26/09 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

fall

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 1 4 3 7 Mapleview Silver Spring, MD

home
Dr., Silver Spring

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

ms/Pus

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

8600 Old Georgetown Rd., Bethesda, MD 20814 Don Shields, MD

31. Date filed (Month, Day, Year) AUG 13 2009

1 Natural

2x Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a, Certifier

32 Registrar's Signature barks

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20009 Wesley Theodore Moger 9:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14305 Jarvis Ave. Ocean City Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 5/15/1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 X M 2 □ F 578-36-4687 Director 80 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show any injury or other traumatic event, the Medical Examinatements be notified at 1X Yes 2 □ No Director MD Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 14305 Jarvis Ave. 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: <u>≽</u> Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Plumbing** 8 Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wesley Otto Moger Helen Cathleen Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna M. Moger / wife 14305 Jarvis Ave., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 8/14/2009 4 ☐ Donation 5 ☐ Other (Specify) Berlin, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) physician at the burial Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day signed by the a I be detached fo 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u></u> 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

BA 5 State Registrar

(Check only one)

Name and add

Year)

AUG 1 3 2009

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:20 PM LOIS ANN PRUITT County of Death Eacility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. Salisbur Hospice AKE the Loastal comico If Under 1 Year | If Under 24 Hrs: 8. Date of Birth (Month, Day, Year) JULY 3, 1951 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 □ M 2 □ F Hours VIRGINIA 58 Yrs 214-60-9673 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2□No ACCOMACK CHINCOTEAGUE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23336 USA 6304 CLARK STREET 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) BEAUTICIAN HAIR STYLING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JESSE KENNETH RHODES LOIS MARIE BOWDEN

1 ☐ Never Married 2 📉 Married 3 Widowed 4 Divorced

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

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Funeral

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Physician/Medical

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at

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**Physician** /Medical Examiner

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director

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within 24 ho To the Fune completely f

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death.

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

1 and 2 should be Health and Mental

Maryland 21215-0036

Baltimore,

72

Elementary/Secondary (0-12) 12

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19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6228 SHARPLEY STREET - CHINCOTEAGUE, VA 23336

(SON) JONITHAN STONE 20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place) JOHN W. TAYLOR CEMETERY

Date 20c. Location - City or Town, State 8/12/2009 TEMPERANCEVILLE, VA

1X Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)

22. Name and Address of Facility

THORNTON FUNERAL HOME 24183 CHADBOURNE ST. - PARKSLEY, VA 23421

23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

is that caused the death.	Do not enter	the mode of dying	, such as cardiac or respiratory	arrest
MRTASTA	TIC	LUNG	CANCRIL	
Due to (or as a conseque				

Approximate Interval Between Onset and Death

IF FEMALE:

Due to (or as a consequence of):

Due to (or as a consequence of):

U. THORNTON

3 Ectopic pregnancy

23d. Date of delivery Month Day

Year

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unkno

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

5 Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? autopsy 2[ 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Jeath

Natural

2 Accident

4 ☐ Homicide

3 Suicide

5 Pending 6 Could not be determined

Year.

28a. Date of Injury (Month, Day, Year) investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

29b. Signature and title of Certifier

31. Date filed (Month, Day,

29c. License number 10058410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hacon WAN

OAS TAL 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Cother (Specify) HOSPICE

26. Place of Death (Check only one

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

B.U Bap 1733 Stas Buyus 21802

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Elwyn C. Pusey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Perry Point Health CAResySTEM A MARYLAND E/W/ If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 16, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Year) 1**∑** M 2□ F Months Hours 76 Director 220-28-0969 Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Deal Island Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 48 21821 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1 953 - 55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status physician : 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 Elementary/Secondary (0-12) College (1-4or 5+) Eleven Years Painter permit. Pages 1 and 2 should be filed \
Department of Health and Mental Hygi 
Important: If Item 27 is marked other 
any in]ury or other traumatic event, II land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 9 unknown ပ unknown Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KNOWN Aime Saylor (Eligibility Clerk) | V.A. Maryland Healthcare System, Perry Point, MD 21902 Baltimore, 20b. Place of Disposition (Name of cemetery, chematory or other place)
Eastern Shore Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 108/1//09 | Hurrock, 1161 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 21. Signature of Funeral Service Licensee AME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conservence of): **Physician** /Medical Examiner Dronary Arter
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): the attending physician The law requires that the death certificate be as IF FEMALE:

d be detached

To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director; After this continue

23b. Was decedent pregnant

☐Yes 2☐No

q | Unknown

in the past 12 months?

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier

Completed by Physician/Medical Be Certification: To

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ylar Recident Old

5 Pending investigation

6 ☐ Could not be

determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

28a. Date of Injury (Month, Day, Year)

a ☐ Unknown

3 Ectopic pregnancy

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ?

> autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 2 No

Day

Year

3. Time of Death

9. Birthplace (State or Foreign Country)
Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

nu pos co

1 Yes 2 □ No

5:45 A

Vear

2009

U.S.A.

Black, White, etc.

unknown

Specify:

14. Race - American Indian,

White

4c. County of Death

Ceci

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Hospital:

Yealth Care System, Perry Point, Mb 21902

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 8:40 PM<sup>M</sup> Leonard Walter Quigley 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County Ceci1 Elkton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Yrs. 31, Delaware Director 222-16-4967 79 1930 Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show office! Examiner must be notified at Director 1 ☐ Yes 2XXXVo New Castle Bear Delaware | 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 53 South Jacqueline Court 19701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XIYes 2 No 1947 If Yes, Give Year or Dates: 1990 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 1990 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, I'm I'm once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Refinery Unit Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Francis A. Quigley, Jr. Beatrice Clineff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 Kane Drive, Newark, Delaware 19702 Cheryl Cermele/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State August 17, Hockessin. Hockessin 4 ☐ Donation 5 ☐ Other (Specify) 2009 Delaware Crematory 21. Signatur Jouler Jervice Lich ee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-trai Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the at be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **No** 1 □Yes 2 No 1 🗌 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25+1 VA

State Registrar

completely

(Check only

100C 31 Date filed (Month, Day, Year)

Ma

and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

W

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( 1- For Registrar #23e per Phy 8/21/09 PGHC ELM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** REEVES 4 2009 KADIJATU Aug 1:10pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Cheverly Prince George's Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 28 1947 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 TF Yrs. Sierra Leone 62 Director 577-74-5201 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rai', or items 23e or 28a-f show Examiner near be notified at 1 DTYes 2 □ No MD Prince George's Hyattsville Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 4801 68th Avenue 20784 Sierra Leone filad within 72 hours aftar death Funera Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 ☐ Widowed 4 反 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Private Nurse other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event, 90cg. 17. Father's Name (First, Middle, Last) Alie Mansaray Amie Kamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aminata S. Ogbolu/daughter 4801 68th Avenue, Hyattsville, MD 20784 20b Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation \_ 5 ☐ Other (Specify) Aug 16 2009 Adelphi, MD George Wash Ceme 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sersis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner attanding physician and for use as the burial-transit The law raquiras that the death cartificata be exacuted ericard resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the th 9 Unknown 9 Unknown s been signad by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2) No 3 Probably 4 Unknown Completed 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes ₽ No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No М 2 Accident Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 1348042 8/05/2009 . Sarraruzi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 CICUITE MD

State Registrar 31. Date filed (Month, Day, Year) AUG 1 4 2003

32. Registrar's Signature

09-06525

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene James D. Ross Certificate of Death 1- For State Registrar

1. Decedent's Name (First, Middle,Last) Time of Death 2. Date of Death Physician/ Month August 21, 2009 0330 hrs Medical Examiner James D. Ross c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's 6549 Hil Mar Drive #202 District Heights If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** oreign Days Hours Months Director Country) VA Feb.25,1951 577-66-6175 58 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 No s 23a or 28a-f show e notified at once. MD PG Forestville t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene. rrant: If item 27 is marked other than "natural", or items 23a or 28a-f shu y or other fraumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country 10e. Street and Number 6549 Hil Mar Drive #202 20747 United States Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Funeral 11. Marital Status Was Decedent Ever in U.S. White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: Black If Yes. Give Year Widowed 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 None None 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claudine A. Latane

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston J. Ross 19a. Informant's Name/Relationship (Type, Print ) 6549 Fore Hil Mar Drive #202 Preston Ross/brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other place) 8/29/09 Burial 2 X Cremation 3 Removal from State Riverdale Park Crematory Riverdale. Md Donation 5 Other Specify: 22. Name and Address of Facility Hodges & Edwards F.H. 21 Signature of Funeral Service Licensee wa 3910 Silver Hill Rd., Suitland, Md. 20746 23á. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran: 23a,P11,2/,perME, g897 11/3/09 TT hysician/Medical X UNPENDED by the attending physician ached for use as the burial -The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year Month Live birth 3 Ectopic pregnancy Dav Fetal death 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.0 contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions ğ No 3 Probably 4 V Unknown Yes 2 Chronic alcoholism Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed? 1 🗸 Yes ✓ Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 ✓ Yes No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 21, 2009 O.C.M.E. **OCME** Jo. Name and address of person w o completed called of death (tem 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD 32. Registre's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:40p M Thomas Harvey Russell, Jr. 08 07 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 1 M 2 □ F 228-58-9022 Virgínia Director 2/29/44 65 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Funeral Director 1X Yes 2 No MD Prince Georges Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 20744 7410 Lenham Drive United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Never Married 2K Married 1 ☐Yes 2 X No African Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates þ 1 □Yes 2 KNo Specify: 3 Widowed 4 Divorced American Completed or than "natura" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) And Mental Hygiene.

1.27 is marked other than ".

I traumatic even? Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Private/Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THomas Harvey Russell, Sr. Nellie Louise Dixon ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Russell/Wife 7410 Lenham Drive, Ft. Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = 0 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department c Important: If any injury or once. 4 Donation 5 Other (Specify) Chesapeake Crematory 8/15/2009 | Beltsville, MD 21. Signalur of Fyneral Service,Lice 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral with **Physician** Preumoni Restiratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrincipal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonan Hy pertenin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has at director, page 2: Senticemia 2 No 1 ☐ Yes 2 ☐ No 1 □Yes To the HospItal or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Wa case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient မ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number

State Registrar DHMH 17 Rev 1/2001 RICHARD

31. Date filed (Month, Day, Year)

AUG 13

PALMER

Registrar's Signature

southern ducine

MD

1328

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00055120

Suck 310

7 2009

WAShington DC 20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	ryland / I		ent of He ate of De			giene 2 Reg. No.	0.03	27543
	Physicia	n/	Decedent's Name (First, Middle, La     MARION J. ROM	•					2. Date of Dea	ath	∩∩o <sup>Year</sup>	3. Time of Death 2:00 P M
	Medic Examin		4a. Facility Name (if not institution, giv	e street and number)		4b. (	,,	ocation of Death	noodbi	4c. Co	ounty of Death	
	Funeral		Anne Arundel Med 5. Social Security Number   6. 8		<b>r</b> (In yrs. last birl	thdav) If U	Annapo	lis  If Under 24 Hrs.	8. Date of Birt	_	ne Arun	place (State or Foreign
	Funeral Director		579-16-2967	1 □ M 2 💢 F 94	,,	Yrs. Mon	ths Days	Hours Min.	(Month, Da 3/5/19	v Yearl	West.	virginia
-	and s <b>how</b> 1 at	tor	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow						1	0d. Inside City Limits
	e Maryl r 28a-f notifie	Jirec	Maryland Anne Anne Anne Anne Anne Anne Anne An	cundel	Lot	hian	. Zip Code			10 04	en of What Cour	1 🗆 Yes 2 🛣 No
	with the s 23a or	Funeral Director	136 Main Street				2071	1		rog. Citize	USA	nry :
	s filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show dother, the Medical Examiner must be notified at	by Fun	11. Marital Status  1  Never Married 2  Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 24 N	er in U.S.			panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Americ Black, White,	
Maryland 21215-0036	urs afte :ural", c		3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		_	es 2 No			Sp	pecify:	White
-212	ກ 72 ho ອ <b>ກ "nat</b> Medica	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4 or 5+	<u>·</u>	(Give kind o	Usual Occupat f work done du F use retired)	tion uring most of work	ing	16b. Kind	d of Business In	dustry
212	d withir lygiene iher tha nt, the	Be Co	Elementary/Seconday (0-12) 8th		' 5	Sales I					Retail_	<u></u>
land	l be file lental H rked ol tic ever	To B	17. Father's Name (First, Middle, Last) Enrico Mag					18. Mother's Nam Raf	fela Lu		,	
Jary	1 and 2 should be filed wii of Health and Mental Hygie item 27 is marked other other traumatic event, th		19a. Informant's Name/Relationship (			•		nd Number or Rura			own, State, Zip (	Code)
	1 and 2 s of Health item 27 other tra		Jackie Lambert/ 20a. Method of Disposition		20b. Place o	of Disposition	(Name of	, Lothia	n, MD Z Date		ation - City or To	own, State
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	cify)	1	Hi11	or other place, Cemeter	ry 8/12/			land, M	
Ba	permit. Departr Imports any inji		21. Sign of Funeral Septin Lice	fisee				of Facility GEO				L HOME MD. 21037
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	one cause on each line.		not enter the	mode of dying,	, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ather			c (a	rc)10 VC	scular	dis	easo	Onset and Death
-	Examiner	<u>_</u>	Sequentially list conditions,	b. —		. 0.						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	consequence	01):						
	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence	of):						
3760	ficate b g physi as the t	Medical	IS SEEMALS	d								
Box 68	ath cert attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at	Fetal deat		pic pregnancy er (specify)	,		23	d. Date of deliv	ery Day Year
Ö.	the dea by the a cached	hysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	g 🗌 Unknown								
s, P.O.	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	by	Part II. Other significant conditions  OSTED POND	-	t not resulting	in the underly	ring cause give	en in Part I.				he cause of death? bably 4 Unknown
ord	w requi	Completed	Anaemia						24a. Was auto		24b. Were auto	psy findings available impletion of cause of
Rec	sician: The law certificate has irector, page 2 a		Deep veir	throv	nhosi	Ľ			1 Tes	ormed? 2 No	death?	
Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 <b>E</b> R/O	utpatient 3 [	Othor	ce of Death (Checi r: 4 □ Nursing Ho		dence 6	Other (Specif)	·)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		Time of injury	28c. Injury work?	at ∕es 2 □ No	28d. Describe h	now injury o	occurred	-
Division of Vital Records,	r Attenter deat rector:	Certificate:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be Ricco of Injur	ry - At home, fa				28f. Location (S		Number or Rura	l Route Number,
á	spital o		29a. Certifier 1 Certifying Ph	ysician: To the best of n		death occure	ed at the time,	date and place, ar			manner as state	ed.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu		amination and/	or investigatio	n, in my opinior occurred at the	n, death occurred a time, date and place	t the time, date a	and place, a ne cause(s) a	nd due to the ca and manner as s	use(s) and manner stated. ated.
	<b>7</b> wit		29b. Signature and title of certifier	m.c. St	YOU	>	29c. License   <b>D</b> · 5	0653			signed (Month,	Day, Year)
11	17		30. Name and address of person who				GYA	N.C.	Surp	NA		20751
7	Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature			oad	real	6	MD	2011
	Registr	ar	AUG 11	2009 12	a d	he	41					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Ce	ertificate of D		Re	g. No.	
Physic	ian	1. Decedent's Name (First, Middle, Last)  Gloria Rose Rogers				<ol> <li>Date of Death Month</li> <li>Auq.</li> </ol>	Day Year 2009	3. Time of Death 9:20 A M
/Medi Exami		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or L	ocation of Death	Aug.	4c. County of Death	
e Addin		Anne Arundel Medical Cer	nter	Annapo]			Anne Aru	
Funeral Director		220-09-5773 1□M 2ÅF	7. Age (In yrs. last birthday 87 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 14,	Year) 9. Birth Con 7. 1921 Maj	nplace (State or Foreign untry) Cyland
Maryland a-f show	ctor	Usual Residence of Decedent  10a. State MD  10b. County Anne Arundel	10c. City, Town or L Arnolo					10d. Inside City Limits 1 ☐ Yes 2X No
th with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 640 Oakland Hills Drive	e, Unit 2B	10f. Zip Code	21012	10	g. Citizen of What Col	untry?
be filed within 72 hours after death with the Maryland tall Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Expriner must be redified at	b	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Deced Armed For 1 □ Yes 2 If Yes, Given Year or Da	5 <b>∑</b> V₀	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 X No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amel Black, White Specify: W	
fled within 72 hc Hygiene. other than "natu	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-	(Give	edent's Usual Occupat e kind of work done du DO NOT use retired) lospitality	ion ring most of workii	ng 1	6b. Kind of Business/I	
illed Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, M	aiden Surname)	
y can should be nd Mental marked c	To B	James L. Hawkins			Nellie	DeBraufi	re	
nd 2 should be file alth and Mental Hy 27 is marked othe r traumatic event,		19a. Informant's Name/Relationship (Type. Print) Steven Turner / Son	1				City or Town, State, 2	21401
permit. Pages 1 and 2 should by permit. Pages 1 and 2 should by Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic en any Injury or other end and Injury or other end		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Removal from S  4 □ Donation 5 □ Other (Specify)	20b. Place of Disp tate Glen Hav	position (Name of ematory or other place) ren Memoria Park			Oc. Location - City or Glen Burni	•
permit. Departimonts any Injury		21. Signature of Funeral Service Lines (2)	Some 4		of Facility Sons, P., tchie Hw	A. Sever	na Park Fu na Park, M	neral Home D 21146
Physician /Medical Examiner				nter the mode of dying	, such as cardiac c	or respiratory arre	st,	Approximate Interval Between Onset and Death
tificate be executed g physiclan and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Dicease or knur) that initiated events  c	r as a consequence of): r as a consequence of):					
attendir for use	Physician/Medi	in the past 12 months?	ant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
quires that		Part II. Other significant conditions contributing to dead Acute Real Fo	ath but not resulting in the	underlying cause giver	in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pr	the cause of death?
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed by					24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
sician certifi rector	Be	25. Was case referred to medical examiner?		Other	26. Place of Death			
Physer this sral di	1: To	1  Yes 2  No  No  1  I  I  I  I  I  I  I  I  I  I  I  I	patient 2 ER/Outpatie f Injury 28b. Time	of 28c. Injury	at Nursing Ho	me 5 ☐ Resider 28d. Describe hov	nce 6 Other (Spec w injury occurred	cify)
for Attending after death. Director: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of determined	of Injury - At home, farm, sign etc. (Specify)		es 2 No	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ıral Route Number,
Hospital (24 hou sa) Funeral D	Medical Cer	29a. Certifier (Check only one) (Check only one)	sis of examination and/or i					
To the within To the comple	A Med	29b Signature and title of certifier		29c. License	number 5879	29	9d. Date signed (Month	0
HID		30. Name and address of person who completed cause  Howard Young MD	of death (Item 23a) (Type	p, Print)	woul	colu	Anna	125 MD 2
St Regist	ate rar		distrar's Signature	back				

#234 423

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 13, 2009 **Physician** RAYMOND PERRY STEWART 11:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ENVOY HEALTH CARE DENTON CAROLINE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Director 220-12-1477 90 08/28/1918 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exstrainer must be a coffect at Director 1XYes 2 □ No MD Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 420 Colonial Drive 21629 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ∐Yes 2 XNo 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Canvas 0 11 Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John N. Stewart Nannie L. Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as
Important: If item 27 is 1 Raymond P. Stewart, Jr.,/son 191 Irish Hill Road, Felton, DE 19943 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Woodlawn Memorial Park08/17/2009 Easton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Preumonia /Medical De to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 I Inknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ advance d 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 certificate 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ 📈 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 5 Pending investigation death. ours after death.

neral Director: /
filled in by the for M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 0005325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BU Preston Lednum nelinda 700

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

AUG 14 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death

55

**Physician** /Medical Examiner

1 \_ For State

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy lolury or other traumatic event, If e Medical Examinan must be notified at once.

Stansbury, Roger

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

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		e (First, Middle, Las HILIP STA	·						2. Date of De Month	D	1	ear .	3. Time of Death
			e street and number)			4b. City, Town	, or Locatio	n of Death	Augus		c. County of	Death	リンタキ
	lemor		spitala	I Ea	Ston	Fa	Stor				Talk	- N-	
	ocial Security Nu	umber 6. S	ex 7. Age		st birthday)	If Under 1 Year Months Day	r If Und	er 24 Hrs.	8. Date of Bir (Month, Da	rth av Year			ce (State or Foreign
	12-28-71		X M 2 D F	77	Yrs.	Wioning Day	- Hours	I VIIII	MARCH				YLAND
	al Residence of State	Decedent 10b. County		10c City.	Town or Lo	ncation			-			10d	. Inside City Limits
	MD	TALBOT		EAST		, oanon						100	TXXYes 2 □ No
100	. Street and Num			LIGIU I	····	10f. Zip Code				10a C	itizen of Wh	at Country	
5 100.												ar oourna,	•
D 11.1	<b>29800 Dt</b> Marital Status	JSTIN AVE	12. Was Decedent E	ver in U.S.	13.	21601 Was Decedent of	f Hispanic (	Origin? (Sp	ecify Yes or No	US.	14. Race -	- American	Indian,
5 1		ed 2 Married	Armed Forces? 1	0		If Yes, specify C			Rican, etc.)			White, etc	
2 3	3 ☐ Widowed		Year or Dates:			1 □Yes 2 🛣 N	o Speci	ny:			Specify:	HITE	
מנפי	(Speci	15. Decedent's Ed	ucation de completed)			dent's Usual Occ		ost of worki	ina	16b. I	Kind of Busi	ness/Indus	stry
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Ď		First, Middle, Last)								, iviaide	n Surname)		
	OGER STA	ANSBURY me/Relationship (7	Tupo Print)		10h 14=:#:	na Addron- /Ci		Y QUI		or Ca	or Town	tata 7:- 0	ada)
4		TANSBURY	,,	Ī		ng Address (Stre						iate, ZIP C	oue)
1	. Method of Disp		/ WILE	20b. Pla		osition (Name of matory or other p			Date		Location - C	ity or Towr	n, State
	1√2 Burial 2 □		Removal from State				i	00/1	7./2000	11210			
-		peral Service Licen		MD E		2. Name and Add			//2009	HUK	LUCK,	MD	
	11	0///						•	N & NEW	MAM	RIINE	RAT. H	OME, P.A.
23a	Part 1. Enter th	ne disease, or comp	olications that caused	the death.	Do not ent	ter the mode of c	ARRTS lying, such	on ST as cardiac	or respiratory a	arrest,	MD; 2	LOU A	pproximate
Imn	shock, or hear nediate Cause (I	rt failure. List only o Final	one cause on each lin	e.	200					-		11	nterval Between Inset and Death
dise resu	ease or condition ulting in death)		a. Ohrov			struct	ive	Puln	nonary	-Vi	sease	-	1 d
				conseque	illoc oij.								
Seq if an	quentially list con ny, leading to imr ise. Enter Under use (Disease or i	nditions, mediate	Due to (or as a	conseque	nce of):								
n I that	initiated events	100	c										
resu	ulting in death) L	ast	Due to (or as a	conseque	nce of):								
2			.d										
IF F	EMALE:											1	
	. Was decedent in the past 12 r	pregnant	23c. If yes, outcome of Live birth	2 ☐ Fetal c	death 3						23d. Date Mont	,	
200	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4 ☐ Pregnant at 9 ☐ Unknown	time of dea	ath 5	Other (specify)					Work		ay (Ou)
Part		icant conditions or	ontributing to death bu	t not result	ing in the	nderlying cause	given in Par	rt I	23e Did	tobacco	use contrib	ute to the	cause of death?
3	e orgilli	ounditions of	butting to dout to	163411	u		g. FOITHII A	. 1.	1 12				oly 4 🗆 Unknown
			<del> </del>							•			
-									24a. Was		24b. We	ere autops or to comp ath?	y findings available letion of cause of
									1 □ Yes	2 <b>/2</b> N	lo 1 E	Yes 2	Z/Vo
25.	Was case referre	r .	Hospital:			10	thor:		h (Check only				
27 N	1 ☐ Yes 2 <b>②</b> N Manner of Death	MO	1 (Anpatie		R/Outpatier 28b. Time of	IL 3 DOA			me 5 Res				
	1 🕰 Natural	5 Pending investigation	(Month, Day	(Year)	Injury	W	ijury at /ork? □Yes 2	_ 1	ZUG. DESCRIDE	now mjt	ury occurred		
3	2  Accident 3  Suicide	6 ☐ Could not be	_	ry - At hom	ne, farm, str			-	28f. Location (	Street =	and Number	or Rural F	Route Number
4	4 Homicide	determined	28e. Place of Inju building, etc	(Specify)	.,, 00		-		City or To	wn, Sta	te)	J IGIUI I	
25. \\ 27. \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	ı. Certifier	1 Certifying Ph	yslcian: To the best o	f my know	ledge, deat	h occurred at the	time, date	and place.	and due to the	cause	(s) and man	ner as sta	ted.
	(Check only one)	2☐ Medical Exam	niner: On the basis of and manner sta	examination	on and/or in	nvestigation, in m	y opinion, o	death occur	red at the time	, date a	nd place, an	d due to th	ne cause(s)
29b.	. Signature and t	title of dertifier				29c. Lice	ense numbe	er		29d. D	ate signed (	Month, Da	ay, Year)
	•	7/	Mi			02	448	8		8	- 11-	200	9
30.1	Name and addre	ess of person who	completed cause of de	ath (Item 2	23a) (Tyne	Print)						1 -	
	Bennet		MD, Z	219	5. 1	washi-	igton	5+	, Ea	Sto	и,	NIJ	21601
31. [	Date filed (Monti	h. Day Year) -	2000 32. Registra	r's Signatu	re	1	7				/		
		HUU [3]	2009 Senon	m,	B. A	Parket							

State

Registrar

AVIFP

# Baltimore, Maryland 21215-0036

P.O. Box 68760 Division of Vital Records.

		For State Registrar	Plea				d / Dep		of H	Ensure A lealth and I	Mental Hy		egible.	27552	
Physici /Medi		1. Decedent's Name  Edwin Decedent			1						2. Date of Dea Month August	ath	2009 <sup>Year</sup>	3. Time of Death 12:10 AM	
Exami		4a. Facility Name (1 9440 Newl				er)		4b. City, 7 Potor		Location of Death			County of Dea		
Funeral Director		5. Social Security N 249–28–56	Number	6. Sex		Age (In yrs.	last birthday, Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birn (Month, Da Jan 27	th y, Year) 192	9. Bir Co Sou	thplace (State or Foreign ountry) Ch Crolina	
rland ow		Usual Residence of 10a. State	f Decedent 10b. County			10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits	
he Mary 28a-f sh	ector	MD	Monto	gomery	7	Pot	omac	10f. Zip	Code			10a Citiz	en of What Co	1 □Yes 2 No	
a or 3	Dir.	10e. Street and Nu 9440 New		Drive	± #114			208				USA		,	
72 hours after death with the Maryland returner, or items 23a or 28a-f show digal Evan her must be notified at	by Funeral Director	11. Marital Status 1 □ Never Marr	ried 2 <b>X</b> Mar	12.	Was Decede Armed Force X Yes 2	es? □No		Was Deced If Yes, spec	_	lispanic Origin? (S an, Mexican, Puert <i>Sp</i> ec <i>ify:</i>	pecify Yes or No o Rican, etc.)		4. Race - Am- Black, Whit Specify: Wh	te, etc.	
72 hours "natural",	Completed b		15. Deceder	nt's Educati	Year or Date on ompleted)	1942	16a. Dece	edent's Usua e kind of wor	k done i	during most of wor	king		/Industry		
within lene. than	dmo	Elementary/Seco	ondary (0-12)		College (1-4	or 5+)		DO NOT US nician	e retired	a)		Utility Company			
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" any hijury or other traumatic event, Its Medical Expone.	To Be C	17. Father's Name John Leo		Last)						18. Mother's Nar Katherin	e Johnso	on			
und 2 shoralth and 1		19a. Informant's N				fe				and Number or Rue Dr. #11		ac, M	D 2085	4	
Pages 1 and of He		20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation		noval from Sta		Place of Disponder			natory 08	/12/09		cation - City o		
permit. Departin Importa any Inju		21. Signature of F	Signature of Funeral Service Licensee  MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 2102												
	ı	23a. Part 1. Enter shock, or her Immediate Cause	art failure. Lis	t only one	cause on eac	sed the dea h line.	th. Do not er		_					Approximate Interval Between Onset and Death	
Physician /Medical		disease or conditi- resulting in death)	on	a		as a consec	quence of):								
Examiner	_	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease o	onditions, nmediate	b	Metast Due to (or	atic E		Cancer							
cate be executed physician and the burial-transit	cal Examine	cause. Enter Und Cause (Disease o that initiated event resulting in death)	ts .	c	Due to (or	as a consec	quence of):								
The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the last	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1	2 months? □No	230		th 2 Fet nt at time of	al death 3	Ectopic p		су		2	23d. Date of d Month	lelivery Day Year	
uires that to signed by Id be detact	þ	Part II. Other sign	ificant condit	ions contri	buting to dea	th but not re	sulting in the	underlying c	ause giv	ven in Part I.				to the cause of death?  Probably 4  Unknown	
The law requir	Completed										24a. Was auto perf 1 □Yes		prior to death?	autopsy findings available o completion of cause of ? es 2 □ No	
Physician: The rithis certificate haral director, page	Be	25. Was case reference examiner?			spital:		7		. Oth		ath <i>(Check only</i> Home 5 Res		2	7. )	
ding Phys h. After this funeral di	tion: To	27. Manner of Dea	ath 5 Pend		28a. Date of		28b. Time Injury		28c. Inju Wo	4 🗆 Nursing	28d. Describe			респу)	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification:	2 Accident 3 Suicide 4 Homicide	6 ☐ Could	- 1	28e. Place o building	f Injury - At I g, etc. <i>(Spec</i>	nome, farm, s	street, factor	, office		28f. Location City or To	(Street an own, State	d Number or	Rural Route Number,	
Hospita 24 hours Funeral etely filler	Medical C	29a. Certifier (Check only one)	1 Certify	ing Physical Examine	cian: To the b r: On the bar and manne	sis of examin	owledge, de ation and/or	ath occurred investigation	at the t	time, date and plac opinion, death occ	e, and due to the curred at the time	e cause(s) e, date <i>a</i> nd	) and manner d place, and d	as stated. ue to the cause(s)	
_	Me	29b. Signature an	d title of certif	0	7/10	$\supset$		i		se number			te signed (Mo	nth, Day, Year)	
1041		30. Name and add		n who com	pleted cause	of death (Ite	em 23a) (Type				or Kills				
SI Regis	tate trar	31. Date filed (Mo	ANSNI Onth, Day Yea AUG		09 <sup>32. R</sup>	gistrar's Sign	nature 1	park	1	# 409 R		1 '			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1:30 A<sup>M</sup> 8, 2009 Gertrude Hildegard Supik August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House 8. Date of Birth (Month, Day, Oct 24, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F Germany Director 364-40-3216 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 12005 Edgepark Court 20854 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ent of Health and Mental It: If item 27 is marked of y or other traumatic ever Agnes Mathilda Amrhein Hans Wirges ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frank John Supik/son 1623 Crescent Lane McLean, VA 22101 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any injury or once. Final Journey Crematory 08/12/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Homes Cremation Service P.O.Box 784 EMO1251 Beverly L. heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) physician the burial Physician/Medical attending pl for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ØNo 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No 1 TYes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}$  XOther (Specify) hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 24 hours after death.
Funeral Director: Afetely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Konertchou, mo D63748 August 10, 2009 10 EG-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Rd. Rockville, MD 20855 Jocelyne Kouatchou, M.D. 31. Date filed (Month, State park Registrar

Box 68760.

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:15 PM 2009 William Ausherman Sowers Aŭgust /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5542 Burkittsville Rd. Frederick Burkittsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD Social Security Number 8. Date of Birth (Month, Day, Year) 9/11/1928 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 218-30-9147 80 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show the Medical Exercitors must be notified at MD Frederick 1 ☐ Yes 2 ▼ No Burkittsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 5542 Burkittsville Rd. 21718 USA 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Mudical Experience once. Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 3√□No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) aluminum co. lineman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Sowers Anna Ausherman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2176919a. Informant's Name/Relationship (Type. Print)
Roxie Sowers (Wife) 5542 Burkittsville Rd., Burkittsville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method/pf Disposition X B fia 2 ☐ Cremation 3 ☐ Removal from State Pleant View Cem. 8/12/2009Burkitsville, MD 5 ☐ Other (Specify) 4 Donation of Funeral Serv Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physiclan for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months: Month Day 5 Other (specify) 1 ☐Yes 2 ☑No ed by the a 9 ☐ Unknown 9 ☐ Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performe certificate 1 □ Yes 2 □ 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 24 hours after death.

Funeral Director: After thi letely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/200

State

31. Date filed (Month

11 -20

MD

Elmson

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

homas

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/13/2009 2:10 $A^{M}$ Evelyn H. Sanders 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Copper Ridge Nursing Home Carrol1 Sykesville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 6/19/1923 Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days Hours Min. 1 □ M 2 🖾 F Virginia 578-20-9280 86 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 X No Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 2111 Lewisdale Drive 20783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 X No Specify Specify: 3 X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary PG Co. Board of Educat. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hall Harrison Odelle Eley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Sanders / Son 2111 Lewisdale Drive, Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery: 8/17/2009 Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue ( Stemetta Hyattsville, MD 20781 Gasch's Funeral Home, PA 23a. Part 1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death immediate Cause (Final heine disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 🗌 Unknown /n

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

items 23a or 28a-f show

72 hours after

permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygjene. Important: If Item 27 is marked other than "natural", or it any injury or other traumatic event, Ite Medical Examples.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be ပ

and burial-tran attending physician for use as the buria signed by the a d be detached f been si has this certificate

The law requires that the death certificate be executed

the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Exami Physician/Medical þ Completed Be Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

Part II. Other significant condition	s contributing to death	but not resulting in the und	derlying	cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?  No 3 □ Probably 4 □ Unknov
				1.000	24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause o death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)	
1 Yes 2-No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpatient	3 🗆 D	OA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	•	njury 28b. Time of Injury	М	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how injur	ry occurred
3 Suicide 6 Could no 4 Homicide determin	28e. Place of I	njury - At home, farm, stree etc. <i>(Specify)</i>	et, factor	y, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
						s) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier			29	c. License number	29d. Da	ate signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature back

09-06184	
00 00 10 1	

Please Type or Print in Black Indelible Ink Finsure All Copies Are Legible.

Benjamin D. Thor			tate o	f Marylaı	nd / D	epartr	ment of	Health	and M	/lental	Hygiene	J	2.1	10 2755
		- For State Registrar	-U = 1 = -4\			Certifi	icate of	Deam		_	2. Date of D	Reg. No Death	. 20	3. Time of Death
Physicial Medical Examin		1. Decedent's Name (First, Mid- Benjamin D.		nas							Month August	8, 2009		0532 hrs
1		4a. Facility Name (if not institut 6432 Woodland Fore			nber)		4	b. City, Tow Elkridge		ation of De	ath	1	c. County of Dea Howard	ath
Europel		Social Security Number	6. Sex		7. Age (in	yrs. last	birthday)	If Under 1	Year I	f Under 24l	Irs. 8. Date of	f Birth(MM	1/DD/YYYY) g. I	Birthplace (State or
Funeral Director	1	577-66-3715		и 2F	59	,	Yrs.	Months	Days	Hours N	Aug	5 195	50 For	eign Country) Wash, DC
	ŀ	Usual Residence of Decedent	-									0.1		10d, Inside City Limits
v any		10a. State 10b. Count	/		100	c. City, To	wn or Locati	on						1 XXYes 2 No
land f shov	5		lveri	<u>t                                     </u>		Owing	S	10f. Zip Co	ala.		74	T10g C	itizen of What C	
Mary rr 28a-	Director	10e. Street and Number												
vith the Maryland 8.23a or 28a-f show a enotified at once,		1655 Fowler I	coad	12. Was Dece	edent Eve	er in U.S.	13. Wa	207 s Decedent	of Hispan	nic Origin?	( Specify Yes o	USA	14. Race - Am	nerican Indian, Black,
eath w	Funeral	1 Never Married 2	Married	Armed Fo			If Y	es, specify C	Cuban, Me	exican, Pue	erto Rican, etc.)	1	White, etc	<b>.</b> .
after d	by F			f Yes, Give Year or Dates:				Yes 2 X				1405	Specify: B1	
hours af "natural"		15. Decedent's Education (Sp				ted) 1		t's Usual Oc ost of workin			of work done retired)	160	, King of Busine	SS/IIIduSii y
5-0036 iled within 72 Hygiene. I other than "	Completed	Elementary/Secondary (0-12	(1)	College (1	-4 UI 5+)		Sales					P	rivate	
5-0036 led within 7 Hygiene. t other than	5	17. Father's Name (First, Midd	e, Last)						18.1	Mother's N	ame (First, Mide			
215 be file ntal H rked c	a	Benjamin F. T						centre-or	F	rance	s A. Ke	ent		7: 0-4:
D 21 should I is man atic ev	٢	19a. Informant's Name/Relatio Mildred Stubb											City or Town, S	tate, ZIP Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If iten 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		20a, Method of Disposition	5/51	ster		20b. Pia	ce of Dispos	ition (Name			wings, Date	200	c. Location - City	y or Town, State
ore lore ges 1.8 trof H		1 Burial 2 X Cremati			om State	1	matory or ot erdale		ator		1/ '	2000	Dirond	lale, MD _
	1	4 Donation 5 Other 21. Sign ture of Funer Servi	Specify: ce Lucus	ee		KIV	22.1	Name and Ad	dress of	Facility J	.B. Jei	ikins	Funera	1 Home
Balt permit Depart Impor injury	10	134	16		_		74	74 La	ndov	er Ro	ad, Lar	ndove	r. MD 2	.0785
Physician		23a. Part I. Enter the disease, failure, List only one cau	se on eac	ch line.						ch as cardi	ac or respirator	y arrest, s	shock, or heart	Approximate Interval Between Onset and Death
/Medical xaminer		Immediate Cause (Final disea or condition resulting in death	_	Chronic Alc				of the Liv	er					Death
1			/ L b.	Due to (or as a	consequ	ience or).								
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	46	Due to (or as a	consequ	ence of):								
	Exami	(Disease or injury that initiated events resulting in death) Las	d 0.	Due to (or as a	consequ	uence of):								
be executed ician and irial - transit	dical E		d.	AMENDED					_	_		_		
10, e be ex ysiciar burial	ledic	UNPENDED  IF FEMALE:		23c. If yes,	outcome	of pregna	ancv						23d. Date of del	livery
68760, certificate be nding physici	ian/Med	23b. Was decedent pregnant in past 12 months?	n the	1 Live t	birth		2 F	etal death	3	Ectopic pr	egnancy		Month	Day Year
Vital Records, P.O. Box 68760 hysician: The law requires that the death certificate this certificate has been signed by the attending physi I director, page 2 should be detached for use as the bu	sic		Jnknown	4 Pregr		ne of deat	<sup>th</sup> 5 0	ther (Specif	(y)			- 1		
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u	Phy	Part II. Other significant con	ditions	and the same of th		out not res	sulting in the	underlying o	ause give	en in Part I	. 23e.	Did tobac		te to the cause of death?
P.O. res that the signed by be detach	d by			<u> </u>							_   1	Yes 2		Probably 4 🗸 Unknown
Division of Vital Records, tal or Attending Physician: The law requirns after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	_									24a.	Was an autopsy	prio	re autopsy findings available ir to completion of cause of
eco he law ate has age 2 s	dmo							.,,			1 🗸	performe Yes 2		Yes 2 No
al R	Be C	25. Was case referred to med						26		the second	neck only one)			
Vit. hysici this c	To E	examiner? 1 ✓ Yes 2 No			Inpatient		R/Outpatier		<u>~</u>		lursing Home		sidence 6 🗸	Other: Scene
n of ding P After funerz		27. Manner of Death 1 ✓ Natural 5 P	ondina	28a. Date (Mont	e of Injury h, Day,Yea		28b. Time of	injury 28		at Work? s 2 N	- 1	cribe flow	injury occurred	
Siol Atten r death ector: by the	cati	2 Accident Ir	ending vestigation	28e Plac	ce of Iniu	rv - At hor	me, farm, stre	eet, factory,				ation (Stre	et and Number	or Rural Route Number, City
Division Spiral or Attend hours after death. uneral Director:	Certification:		ould not l etermined	be		•					or T	own, State	∍)	
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a. Certifier 1 Certifying	Physici	an: To the be	est of my	knowledge	e, death occi	urred at the t	time, date	e and place	e, and due to th	e cause(s	) and manner as	s stated. to the cause(s)
To the vithin To the compl	Medical			and manner	stated.	nation an	a/or investig		License		Tred at the time			(Month, Day, Year)
	Σ	29b. Signature and title of cer	Tiller			11 D		250.	O.C.M			- 1	August 8, 20	
		30. Nam and address of per	son who	complete car	use of dea	/- / /	23a)		_					
UR 5		Russell Alexander		Assistant I				1 Penn S	treet, E	Baltimore	e, MD 2120	1		
	tate	M 4 11 " D /1 /14	ď	32. F	Registrar's	Signatur	e							
Regis		MUGIZEOU	- /-	enu.	, A	19	ODICI		ME					
DHMH 17 Rev 1/2	2001						ORIGIN	AL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eather Parsons

AUG 13

31. Date filed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Day AUGUST 11, JEANNE M. THOMAS

1814 P M

Physician /Medic Examin

for State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any liquy or other traumatic event, it is IM-sical Exercite or must be notified at an any liquy or other traumatic event, it is IM-sical Exercite or must be notified at anones.

Baltimore, Maryland 21215-0036

700 1814

**Physician** /Medical Examiner

De D  $F/n/2a\epsilon \gamma$  Division of Vital Records, P.O. Box 68760,

Jeanne M. Thomas Dass 5/8/1931

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

er	4a. Facility Name (If not institution, give st ATLANTIC GENERAL			4b. City, Town, o		ith	4c. County of Death WORCESTER			
	5. Social Security Number 6. Sex	7. Age (In yrs. i	ast hirthday)		If Under 24 Hr	s. 8. Date of Bi			thplace (State or Foreign	
		M 2X F 78		Months Days	Hours Mir	8. Date of Bi (Month, D 5-8-19	ay, Year)	DEN	NSYLVANIA	
	Usual Residence of Decedent	7.0				J-0-19	71	I EW.	NOTHVANIA	
	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	
ō	DELAWARE SUSSEX	м	T <b>T</b> T <b>3</b> 7TT	T 17					1. Yes 2 No	
rec	10e. Street and Number	FI	ILLVIL	10f. Zip Code			10g, Cit	tizen of What Co		
Ö	31446 OAK STREET			19970	)		US			
era		2. Was Decedent Ever in U.	S 13 1			Specify Yes or N		14. Race - Ame	erican Indian.	
Ë	11. Marital Status  1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ▼No	10.	Was Decedent of H If Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		Black, Whit		
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:			Specify:	WHITE	
Completed by Funeral Director	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occup	ation	. 1	16b. K	ind of Business	/Industry	
ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of w d)	orking				
E	12	College (1-401 5+)	BAN	K TELLER			ВА	NKING		
BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	e, Maiden	Surname)		
얼	EDWARD HICKLING				ID	A WHITE				
-	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or I	Rural Route Numi	ber, City o	or Town, State,	Zip Code)	
	ROBERT J. THOMAS/		31446	OAK STRI	EET, MIL	LVILLE,	DE.	19970		
	20a. Method of Disposition	20b. P		osition (Name of matory or other place		Date		ocation - City or	Town, State	
	1 🔀 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		BETHEL C	:	14-09	OCE.	AN VIEU	DET ALIADE	
	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Solvice (Specify)	TIAK		2. Name and Addre	· ·	14-03	OCE	AN VIEW	, DELAWARE	
	21. Signature of Fuller at Savice A conserv	Melson	ME	LSON FUNI	ERAL SER	VICES, LT	'D			
	So But Edition	nauro_		040 MUDDY				W. DE.	19970 Approximate	
	23a. Part1. En a the disease of complic shock, or heart failure. List only one	e cause on each line.	n. Do not en	ter the mode of dyli	ig, such as cardi	ac or respiratory	arrest,		Interval Between Onset and Death	
	Immediate Cause (Final disease or condition									
	resulting in death)	Due to (or as a consequ	uence of):	***************************************						
	Sequentially list conditions b.									
ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	uence of):						ı	
am	Cause (Disease or injury that initiated events c. resulting in death) Last									
ω̂	resulting in death) Last	Due to (or as a consequent	uence of):						;	
Physician/Medical Examiner	d.									
Med	IF FEMALE:						-		-	
an/	23b. Was decedent pregnant	Bc. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnanc	:V		1	23d. Date of de	,	
Sicient	in the past 12 months? 1 ☐ Yes 2 🗷 No	4 ☐ Pregnant at time of c		Other (specify)	<u>,                                      </u>			Month	Day Year	
hys	9 🗆 Unknowń	3 CHKHOWH								
	Part II. Other significant conditions cont	A			en in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?	
Completed by	Intribr	ral obst	ruels	on		_ 1 🗆	Yes 2	. □ No 3 □ F	Probably 4 Onknown	
lete	,					24a. Wa		24b. Were a	utopsy findings available	
Ĕ						- auto	opsy formed? 2 A No	prior to death?	completion of cause of	
ပ္	25. Was case referred to medical				OC Place of D	1 ☐ Yes eath (Check only		0 1 □ Ye	s 2 No	
Be	eyaminer?	ospital: 1 Inpatient 2 🗆	EB/Outentin	oth	or:			€ □Other (Cr		
Ë	27. Manner of Death	28a. Date of Injury	28b. Time o	nt 3 ☐ DOA ☐ 11		Home 5 Res			ecity)	
ion	1 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	Wor	ḱ? Yes 2 □ No			,		
ical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me form str			28f Location	(Street a	nd Number or F	Bural Route Number,	
ıţ	4 Homicide determined	building, etc. (Specif		eet, lactory, office			wn, Stat			
ပ္	20a Cartifier	ician: To the best of my kno	wladan door	th occurred at the t	me data and si	and due to th	e cause/	s) and manner	as stated	
Medical Certification: To	(Check only 2 Medical Examin	er: On the basis of examina	wieuge, deat ition and/or ir	nvestigation, in my	opinion, death oc	ccurred at the time	e, date ar	nd place, and du	e to the cause(s)	
Med	ONE)	and manner stated.		29c Licens	se number		29d D:	ate signed (Mon	oth, Day, Year)	
_	29b. Signature and title of certifier	29c. License number 29d. Date signed ( <i>Month, Day, Year</i> )								
		D0064120 8/12/2009.				00 /				

State

Registrar

BA6

9733 Healthway Drive Berlin MD 21811.

30. Nameland address of person who completed cause of death (Item 23a) (Type, Print)

Atifzeeshan
31. Date filed (Month, Day, Year)

AUG 13 2009

09-06228 Anthony Craig Trilli

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 27559

,		- For State Certificate of Death		Reg. N	No.	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Mor	e of Death oth Da	y Year	3. Time of Death 1512 hrs
ledical Examin		Anthony Craig Trilli	Αυς	gust 9, 200	4c. County of	
		4a. Facility Name (if not institution, give street and number)  Billingsley Roand & Cattle Place  4b. City, Town, or Location of De White Plains	eatn		Charles	Deali
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Da	ate of Birth(N	/M/DD/YYYY)	9. Birthplace (State or
Funeral Director			Min. D∋	c. 8,1		Foreign CountryWashington
ż	-	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ow any		Maryland Charles Indian Head				1 Yes 2 XNo
Aaryland 28a-f show 1 at once.	황	10e. Street and Number 10f. Zip Code		10g.	Citizen of Wha	at Country?
the Ma a or 28	Director	3455 Laurel Drive 20640			U.S.A	
with the Maryland ms 23a or 28a-f sho be notified at once	al	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?			14. Race - White	- American Indian, Black, , etc.
· death	Funeral	1 Never Married 2 XMarried 1 Yes 2 X No			Specify:	White
s after rral", niner	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind	d of work do	one 16		siness/Industry
2 hour "natu	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)  during most of working life. DO NOT use				
036 ithin 7 ne. r than Tedica	du	12 Meter Tester			Utilit	y Company
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	O	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Last)				
d be fi de be fi fental narked event,	o Be	Carl Delmo Trilli  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number		n Mars		n, State, Zip Code)
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatte event, the Medical Examiner must be notified at once	ř	Marie Trilli Wife 3455 Laurel Drive,				1
e, N I and 2 Health Item 2	ŀ	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Approximately 2 Name of Communication (Name of Communication)	Date		20c. Location -	City or Town, State
nor Pages ent of nt: If		1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other Specify:  August 1  Metropolitan Funeral Se	5, 20	209	Alexand	dria, Virginia
Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatit event, the Medical	İ	21. Signature of Juneral Service Insee 22, Name and Address of Facility	1 How	10 D 7	Α.	
m ga mii	1	M00668 4270 Hawthorne  23a. Part I. F The disease, or complications that caused the death. Do not enter the mode of dying, such as cardi	Rd.	India	an Head	Md 20640
Physician Medical	ľ	failure. Light only one cause on each line.	1100 01 1000	matory amoun	,	Between Onset and Death
caminer	Ì	Immediate of use (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):				
	Ш	Sequentially list conditions, b				
	iner	If any, leading to Immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
.±	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
760, icate be executed physician and the burial - transit		d.				
D, be ex sician	Medical	UNPENDED			23d. Date of	f delivery
876 iffcate ng phy is the t		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pr	pregnancy		Month	
Box 68760, death certificate by the attending physical for use as the but	sician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
Bo he dea	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	l.	23e. Did tob	acco use conti	ribute to the cause of death?
P.O. B es that the de gned by the e detached	þ	Fait II. Other Significant Conditions	- 1	1 Yes	2 🗸 No 3	Probably 4 Unknown
ords, F v requires s been sign should be	Completed		- 1	24a. Was ar	n 24b.	Were autopsy findings available prior to completion of cause of
COF	nple			perform	ned?	death?
tal Recian: The certificate ector, page		25. Was case referred to medical 26.Place of Death (C	Check only			
/ita /siciar nis cer directo	o Be	045-44	Nursing Ho	ome 5 F	Residence 6	✔ Other: Scene
of Ving Physi ong Physi After this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	Mot		ow injury occur struck by a	
ion ttendi leath. tor: /	atio	2 Accident Investigation		Leasting (St	treet and Num	ber or Rural Route Number, City
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway		Taum Ch	ata)	Place, White Plains, MD
ospita hours uneral ly fille		29a Certifier		_		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	urred at the	e time, date a	and place, and	due to the cause(s)
To wit	Med		-		29d. Date sig	ned (Month, Day, Year)
		O.C.M.E.			August 10	), 2009
		30. Name and address of person who completed cause of death (Item 23a)	MD 244	201		
556		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore,  31 Date filed (Month, Day, Year) 32 Registrar's Signature	, IVID 2 1	-U I		
S Regis	tate	AUC 1 2 2000 /2 A Banker				

1	•	-	For State Registrar
		-	

			1 - State Registrar				,		Cer	tificat	e of	Death	h		Reg. N	lo.			
			1. Decedent's Nam	ne (First, Middle	e, Last)									2. Date of D		)av	Voor	3. Time of Dea	
	Physici /Medio		Cecil	Edward	1 1	Watso	n							Month 8	Č	) 2C	Year Year	7:45	PM
4	Examir		4a. Facility Name (					1		4b. City,	Town, o	r Location	n of Death		4	c. County	of Death		
			Coasta	al Ho	spice	at	the	La	Ke	Si	alis	sbu	ryir	nD		w	100	mico	)
Ī	Funeral		5. Social Security N	Number	6. Sex	1 2 F	7. Age (In	yrs. las		If Unde Months		If Unde Hours	er 24 Hrs. Min.	8. Date of B (Month, L	<i>ay, Yea</i>	ır)	Coun		reign
	Director		219-14-3		174,1	. 201	84		Yrs.			L		06-30-	-192	.5	Mary.	land	
	and		Usual Residence of 10a. State	10b. County			100	c. City, 1	Town or Lo	cation							10	Od. Inside City Li	imits
	//aryl	ō	M 1 1					D 4		۸								1 □ Yes 2	No
	with the Maryland a or 28a-f show	rec	Maryland 10e. Street and Nu		set			PTI	ncess	10f. Zip					10g. (	Citizen of W	hat Coun	try?	
	ath with	0	27169 Mt	. Verno	n Ro	ad			21853						USA				
	ter death	Funeral Director	11. Marital Status			. Was Dece		in U.S.	13. \	Vas Dece			Origin? (Sp	ecify Yes or No Rican, etc.)	0-			an Indian,	
(	or ite		1 Never Marr	ried 2 Mari	ried	Armed For 1 Yes If Yes, Giv	2 🔲 No			ires, spe ⊟Yes				riicari, etc.)		Specific			
Š	ours ral",	d by	3 Widowed	4 Divorced		Year or Da	ates: 19	943-	46								Whi		
	ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medeal Evanina must be notified at	Completed	(Spec	15. Deceden cify only highe	it's Educat st grade c	ion o <i>mpleted)</i>			16a. Deced (Give	lent's Usu kind of wo DO NOT u	rk done	durina me	ost of work	ing	16b.	Kind of Bu	siness/Inc	lustry	
Č	within within than than	E G	Elementary/Secondary (0-12) College (1-4or 5+)			-4or 5+)					<i>a)</i>			Home Construction					
7	Hygie Ther		12 17. Father's Name	(First, Middle.		one			car	pente	er	18. Mot	ther's Nam	e (First, Middi				uction	
1	d be ental ced o	o Be	Cecil E									Miı	nnie	Jones					
1	Shoul nd M mari	은	19a. Informant's N			. Print)			19b. Mailir	g Address	s (Street	and Nun	nber or Rui	ral Route Num	ber, City	y or Town,	State, Zip	Code)	
Š	MG 2 alth a 27 is		Catheri	ne Drey	ver W	atson	/wife	2	27169	Mt.	Ver	non l	Road,	Prince	ess Anne, MD 21853				
	or He		20a. Method of Dis				2	20b. Plac	ce of Dispo	sition (Na	me of other plac	ce)		Date	20c.	Location -	City or To	wn, State	
_	Page nent ant: It		1 2 Buriai 2 4 ☐ Donation	☐ Cremation 5 ☐ Other (S		noval from	State I						08-1	2-2009	Mt	. Ver	non,	Marylar	ıd
\(\frac{1}{2}\)	balkimore, Maryliand 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Event once.		2 Signature of Fi	uneral Service	Licensee	`			22 H i	. Name a	nd Addre	ess of Fac	Home						
latsa	TI		MINUS ON WILLIAM NO. MO. MO. 11673 Somerset Ave., Princess Anne, MD. 21853																
3		1	3a. Part 1. Enter the disease, or complications of t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death																
5	Physician	~	Immediate Cause disease or condition resulting in death)	on	_ a.	MET	AST.	ATO	C	9 RC	STE	472		ANCI	21	•			
	/Medical Examiner		resulting in death)			Due to	(or as a co	nseque	nce of):										
.2		ē	Sequentially list co	onditions,	b	Due to	(or as a co	nseguer	nce of):										
e	uted d ansit	Examiner	If any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events c.																
0	an an rial-tr							consequence of):											
1	<b>b8 / bU,</b> tificate be executed g physician and as the burial-transit	Medical			d.														
č	ertifica ling ph e as th	Med	IF FEMALE:															-	
	BOX eath cert attendin for use a		23b. Was deceder		23c	. If yes, out 1 ☐ Live I	birth 2	Fetal d	eath 3[	Ectopic	pregnano	су				23d. Dat Mo	e of delive	ery Day Yea	ır
	the a	Physician/	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   5   Other (specify)   9   Unknown																
	ries that the de signed by the a	Ph/	Part II. Other signi		ons contri	buting to de	eath but no	ot resulti	ng in the u	nderlying	cause div	ven in Par	rt I.	23e. Dio	tobacc	o use contr	ribute to tl	ne cause of deat	
- 6	dS,	d by								,3				1 [	Yes	20 No	3 ☐ Prob	ably 4 🗌 Unki	nown
	COTO w requir s been si should b	Completed												24a. Wa	s an	24h 1	More auto	nev findings ava	ilable
C	He has ge 2 g	mp				_			_					au pe	opsy formed	? - 0	death?	psy findings ava mpletion of caus	e of
7	VITAL HE sician: The Is certificate ha rector, page 2	င်	25. Was case refe	rred to medica								ne Die	and of Doo	1 ☐ Yes		<b>M</b> o 1	1 □Yes	2 □ No	
	ysicie s cert	8	examiner?	£R₀	1	spital:	Inpatient	2 ∏ EF	R/Outpatier	nt 3∏D	OA Oth	nor:		ome 5□Re		8478th	er (Specia	WHOSPIC	12
	on or ding Phys h. After this funeral dir	n:	27. Manner of Dea	ıth		28a. Date	·	2	8b. Time o		28c. Inju Wor		, taronig ri	28d. Describ		_		74 .007	
	a Aff	ațio	Natural 2 Accident		igation	(MOII	in, Day, ro	, (1)	mjury	м		Yes 2	□No						
	LIVISION OT VITAI RECORDS, P.O. I or Attending Physician: The law requires that the daller death. Lirector After this certificate has been signed by the in by the funeral director, page 2 should be detached	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	not be nined	28e. Place buildi	of Injury -	- At hom Specify)	e, farm, str	eet, factor	y, office			28f. Location City or 7	(Street own, St	t and Numb tate)	er or Rura	al Route Number	,
	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours a er death. Funeral Lirector After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Se		0															
8	To the Hospital or Attend within 24 hours a er death To the Funeral Lirector v	edical	29a. Certifier (Check only one)	2☐ Medical	ng Physic I Examine	r: On the b	e best of massis of examples and the stated	aminatio	edge, deat on and/or in	h occurre vestigatio	d at the t n, in my	ime, date opinion, d	and place death occu	e, and due to t irred at the tim	e, date	e(s) and ma and place,	anner as s and due t	stated. o the cause(s)	
	To the within 2 To the Comple	Me	29b. Signature and	define of certifie	er					29	c. Licen:	se numbe	er		29d.	Date signer	d (Month,	Day, Year)	
	V1J		<b>*</b> /\$			2				-	Do	057	3410			2/8	109	7	
			30. Name and add	lress of person	who com	pleted caus	se of death	n (Item 2	23a) (Type,	Print)			•						
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			04 0	-44 F	,		) t · · ·	0:-											
1 h	Sta Regist	ate rar	31. Date filed (Mon	nth, Day, Year,	ו מי מי	32. F	Registrar's	Signatu	re	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** White 4:10 PM Hearn Jane tugust 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Domerset ncess Anne Manokin NH lanor 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours Min. Days 1□ M 2**□** F Months 056-12-7280 Nev. 23, 1916 **Director** Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, Itw Medical Evanimes must be notified at 10a. State 1 ☐ Yes 2 No **Funeral Director** Westover Maryland Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S. A. 21871 31890 Johnson Rd Walter 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ Specify: Black 3 ₩ Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private family Home 10th grade Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ UNKNOWN Jake Hearn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31890 Walter Johnson Rd. Westover, Md Department of Health Important: If item 27 any injury or other trong once. Delores Milbourne - Naice 21871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/15/09 Princess Anne, md, 4 ☐ Donation 5 ☐ Other (Specify) John Wesley Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Anthony E. Ward Funeral Home Anthony 6. Ward 30639 Hampden Ave, Princess Anne, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MOV /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause University of that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 24 hours after death.

Funeral Director: After this certificetely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Many er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 1/2001

Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

dily

Year)

Na FS Ga

completely

within 2. the

5-31V1510N

and manner stated.

1415 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 247094

shell sacisal Ry

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Registrar FH TCHD

1. Decedent's Name (First, Middle, Last) 08/14/09 pha 2. Date of Death Year **Physician** ARTHUR 08 2009 wilson 11 0803 /Medical 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Medical Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months 1 **Y**M 2 □ F 218-40-7354 66 Director 08-05-1943 Md. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notified at 1 ☐ res 2 ☐ No Director Md. Oueen Annes OUeenstown 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ō 6314 Main Street 23a 21658 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. ☐ Yes 2 X No f Yes, Give 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Î No þ 3 ☐ Widowed 4 Divorced Year or Dates: Black "natural" Completed Item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 Is marked other thar 12 Truck Trucking Driver J 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Curtis Wilson, Sr. Martha Slyvester Watkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) April L. Hollis, Daughter 1510 Burrisville Rd., Centreville, Md. 21617
e of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 08-15-09 Gransonville, Md. Bryans Church Cem 22. Name and Address of Facility Bennie Smith Funeral Home 21 Signature of Funery Service Licensee 426 Dover St. Easton Md 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner DM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran HIT~ Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical MARCH as IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? ∕es 2 ☑ No page certificate 1∐ Yes or Attending Physician: ector. 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospitai

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. Ultery 2540 Centrille 31. Date filed (Month, Day, Year)

1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

21617

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air Birthplace (State or Foreign Country) If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖫 F 89 Maryland Director 08/19/1919 217-09-6528 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exprainer, ust by notified an once. 1 ☐ Yes 2 No Director Havre de Grace MD Harford 10g. Citizen of What Country? 10e. Street end Number U.S.A. 1205 Bern Drive 21078 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha S. Bloechl ဂ္ John Gunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timothy S. White (Son) 1205 Bern Drive. Havre de Grace, MD 21078 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forris & Co. Inc. : 08/18/2009 | West Chester, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace. MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACCIDENT STROKE **Physician** CEREBROVAS CULTR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifie 245344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION AVE, HAVRE DE GRACE, MD 21078 622 DHAN

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:55 A M 300x Harrison 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico 22355 Royal Oak Road <u>Quant</u>ico If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours **№** М 2 🗆 F Yrs 9-19-1922 MD 86 215-14-3831 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Wicomico Ouantico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 22355 Royal Oak Road 21856 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent Lvel III 3.5. Armed Forces? 1 X Yes 2 □ No Army If Yes, Give Year or Dates: 4 / 1946 Black, White, etc. 1 Never Married 2 Married 1∐Yes 2∐XNo Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Industry 11th Lumber Cutter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harrison Samuel Wright, Sr. Lydia Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 Queen Ave, Salisbury, MD 21801 Lice of Disposition (Name of Date 20c. Location - City or Town, State <u>Elizabeth Wright/Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 8-14-2009 Beulah, MD 4 ☐ Donation 5 ☐ Other (Specify) -22. Name and Address of Facility 917 W. Isabella St Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Pancrealilis months to year Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 T Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown myeloma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No

**Physician** /Medical Examiner

> burial-tran and

the

attending pl

page 2 should

certificate

: After this certific funeral director,

within 24 hours after death.

To the Funeral Director: A

physician

law requires that the death certificate be executed

Hospital or Attending Physician: The

To the I

death.

Division

of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event.

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Medical Certification: To

MD

**Funeral** 

Director

id other than "natural", or Items 23a or 28a-f show event, the Madical Expression at the notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

D0052255

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

bessfeake Dr. Cambridge, MD 21613

Registrar

31. Date filed (Month, Day, Year)

AUG 1

830 32. Reg/strar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	<b>-</b>		Registrar  1. Decedent's Name (First, Middl	o Lost)	Cer	uncate or	Death			12	. Date of Dea	eg. No.	24	3. Time of Death
lec	Physicia lical Exami			Hugo Migdael Cambara Zuniga							Month Day Year August 16, 2009		1609 hrs	
ingo inguaci company					b. City, Tov	vn, or Lo	cation of				ounty of Deat	h		
			14300 Block of Oak G				Upper l	Marlbo	ro			Prin	nce Georg	e's
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ist birthday)	If Under		If Under		8. Date of Bi	th (MM/DD	/YYYY) 9. Bi Forei	rthplace (State or
	Director		None	1X M 2 F	28	S Yrs.	Months	Days	Hours	Min.	04/03	/1981		ountry Guatemala
		H	Usual Residence of Decedent				<u> </u>							
	any		10a. State 10b. County		10c. City,	Town or Location	on							10d. Inside City Limits
	Aaryland 28a-f show 1 at once,	5	Md Prin	ce George	e Si	lver Sp	ring							1 XYes 2 No
	Aaryl: 28a-f	Director	10e. Street and Number				10f. Zip C	ode			1	l0g. Citizen	of What Cou	ıntry?
	death with the Maryland or items 23a or 28a-f sho must be notified at once,		1003 Merrima	ck Dr.				903		_			temala	
>	n with	Funeral	11. Marital Status		cedent Ever in U.		Decedent es, specify				cify Yes or No ican, etc.)	o- 14	. Race - Ame White, etc.	rican Indian, Black,
	death or ite	ä	1 X Never Married 2 M	1 Yes	2 X No								77.	
	hours after natural", Examiner	ρ		orced If Yes, Give Ye		16a. Decedent	Yes 2						d of Business	ispanic
	hour 'natu		15. Decedent's Education (Spe Elementary/Secondary (0-12)		(1-4 or 5+)		ost of worki					1	d or basiness	, modesty
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	5-0036 ited within 72 hours after Hygiene. fother than "natural", the Medical Examiner.	Completed	17. Father's Name (First, Middle	, Last)				18	3.Mother's	Name (I	First, Middle,			
	21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Eulalio de J	esus Camb	ara Chin	chilla			Paul	.a Zı	uniga	Godoy		
	21, buld to 1 Men s mar		19a. Informant's Name/Relations						and Numb	er or Ru	ral Route Nu	mber, City	or Town, Sta	
	MD d 2 sho Ith and n 27 is sumat		Elvia Nohemi	Cambara/									, Md 2	
	_ = 8 = 2	1	20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Demoval		Place of Dispos crematory or oth		of ceme	etery,		Date	20c. Lo	cation - City o	or Town, State
	Baltimore, sernit. Pages 1 a Department of He Important: If its injury or other tring		4 Donation 5 Other S			General	Ceme	tery	,	08/2	8/09		uatema	
	Baltimo permit. Page Department o Important:		21. Signature of Funeral Service	Licensee.	1 + 1	22. N	lame and A	ddress	of Facility	John	T. Rh	ines	Funera	al Home 3005
	E E E		Phone		les 10	7/112	th. S	T NE	Was	hina	ton D.	C. 20	0017	
	Physician		23a. Part I. Enter the discussion of failure. List only one cause	complications that on each line.	caused the death	. Do not enter th	ne mode of	dying, s	uch as ca	rdiac or	respiratory a	rest, shock	c, or heart	Approximate Interval Between Onset and
	/Medical xaminer		Immediate Cause (Final disease		gulation									Death
			or condition resulting in death)	Due to (or as	a consequence o	f):								
		ē	Sequentially list conditions, if any, leading to immediate		a consequence o	f):								
		틭	cause. Enter Underlying Cause (Disease or injury triat initiated	С.										
b	ed	Examiner	events resulting in death) Last	Due to (or as	a consequence o	1):								
	e executed cian and rial - transit	dical	XUNPENDED	AMENDED	23a,27,	28a-f,	erME,	, g8	95 97	870	9 TT			
	_• S .⊡.E	ledi	IF FEMALE:		s, outcome of preg							23d.	Date of delive	ery
	1876 Tiffica ing ph as the	Ž	23b. Was decedent pregnant in t past 12 months?	ho .	birth		tal death	3	Ectopic	pregnar	псу		onth	Day Year
	Box 68760, e death certificate but attending physical for use as the but	sician/Me		known	gnant at time of de	eath 5 Ot	her (Spec	fy)						
	O. Bc	Phys	Part II. Other significant condi	9 Ulik	nown	coulting in the I	undorlying :	nause di	ven in Dar	+ 1	23e Did	tohacco us	se contribute	to the cause of death?
	that th	by	Part II. Other significant condi	uons commouning	to death but not i	esulariy iii ale c	indenying i	Jause gr	VCII III I EI					robably 4 Unknown
	IS, P quires a en sign uld be o	Completed									24a. Wa	s an	24b. Were	autopsy findings available
	cords, law requir has been s 2 should	l de	V									opsy formed?	prior t death	o completion of cause of ?
	Rec The I icate I page	Į.									1 🗸 Yes		1 🗸	Yes 2 No
	ician: The cirian: The circuit cate rector, page	Be (	25. Was case referred to medic examiner?	Hospital:		1		10	of Death (			75	0.40	
	F Vir Physic r this	힏	1 <b>✓</b> Yes 2 No		Inpatient 2	ER/Outpatient			at Work		Home 5 28d. Describ		ce 6 🗸 Oti	ner: Scene
	Division of Vital Records, P.O. tat or Attending Physician: The law requires that the state death  In Silve death  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacl		27. Manner of Death  1 Natural 5 Per	iding 20a. Da	te of Injury nth, Day,Year)	28b. Time of I	injury 2		es 2 X				s stra	ngled
	ivision or Attend after death Director:	cati	2 Accident Inve	estigation Fd	8/16/09 ace of Injury - At h	Fd 3:5	pm et factory							
	Divi	Certification:	dete	ild not be /Specif	Found:	up a hi	11 of	fr	oadwa	ıy	or Town	State)14	300bl	Rural Route Number City Of OAK Grov MD
	lospit f hour uners		4 X Homicide 29a. Certifying F	hysician: To the b						- 1				
	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the by	Medical	one) 2 Medical Ex	aminer: On the basi	s of examination a	and/or investiga	tion, in my	opinion,	death occ	curred at	the time, da	te and plac	e, and due to	the cause(s)
	wit To	Me	29b. Signature and title of certifi	and manne er	stated.		29c	License	number	-		29d. D	ate signed (/	Month, Day, Year)
	V		my hi	, w.	3			O.C.N	Λ.E.			Augu	ust 17, 200	09
			30. Name and address of perso	n who completed ca										
				ant Medical Ex	aminer 111	Penn Stree		nore, l	MD 212	01				
		tate	31. Date filed (Month, Day Year AUG 24	2009	Registrar's Signat	* pau	Lis .							
	Regis	trar	AUU AT	2003	The party of			·						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 8894 8-28-09 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 08-25-2009 4:30 P Christine Andrews Margaret /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 9501 Burton Ave. Carney If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 🖫 F 88 Yrs. 09-06-1920 Maryland Director 213-18-3482 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2√ No Director MD Baltimore Carney 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 21234 9501 Burton Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 □ No Specify: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by White 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fitzpatrick Andrew Manning Gertrude ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 Burton Ave., Carney, Maryland Marian Cosentino (Dtr) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/28/09 Baltimore, MD Bayview Crematory 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, MD Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Que to for as a consciouerios the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Bor 68760, 🖔 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown

ed by the a has in 24 hours after geaus.
the Funeral Director; After this related filled in by the funeral di this

2

Completed

Be

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Certification:

Medical

Division of Vital Records,

	EMALE:
23b.	Was decedent pregnant
	in the past 12 months?
	1 ☐ Yes 2 ☐ No
	g 🗌 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 □ Yes

25. Was case referre	d to medical	
examiner? 1 ☐ Yes 2 ☐ N	6	Γ
27. Manner of Death		
1 Natural	5 Pending	

6 ☐ Could not be

2 Accident

3 ☐ Suicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

White Marsh Medical Center 9649 Belair Rd. Meeta Gulati Balto. Md. 21236

State Registrar

L

31. Date filed (Month, Day, Year) 32. Registrar's Signature



within 2 To the

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0032 AM 2009 Edward Henry Addison, Sr. Haust /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/ABaltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min. M 2□F 82 Yrs. May 20, 1927Alabama Director 420-38-0070 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1⊠Yes 2□No Baltimore Director N/AMaryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21218 1508 Lakeside Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. I ⊠Yes 2□No If Yes, Give Korea Year or Dates, Orea 1 Never Married 35 Married Specify: Black 1 ☐ Yes 2Ñ No Saltimore, Maryland 21215-0036 Specify: δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pagas 1 and 2 should be filad within 72 Department of Health and Mantal Hygiene. Important: If item 27 Is marked other than "nat any injury or other traumatic event, the Macilia once. Compi Elementary/Secondary (0-12) College (1-4or 5+) Baltimore city Suspension Counselor 4+17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ella Clifton Jacob Addison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1508 Lakeside Avenue Baltimore, Maryland Ernestine Addison/ Wife 21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/27/09 et. cem. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Owings Mills,MD Garrison forest Vet. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licersee 5240 Reisterstown Rd Baltimore, MD 21215 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 20 min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for usa as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an has 1 ☐ Yes 2 D No 200 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of of or Attending Fafter death. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 52016 Damara. Waiel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 rd 200 East Samara Maiel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 28 Registrar

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Nicholas Agthe /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 1 5 5. Social Security Number . Age (In vrs. last birthday) **Funeral** 1 XM 2 - F Aug. 21, 2009 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location items 23a or 28a-f show ler must be notified at Funeral Director Baltimore Maryland 10f. Zip-Code 10e. Street and Number 306West Franklin Street Apt.503 21201 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No

College (1-4 or 5+)

**Physician** /Medical

ortant: If item 27 is marked other than "natu injury or other traumatic event, the Medical

þ

Completed

Be

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

0

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

21. Signature of Funeral Service Licenses

15. Decedent's Education

(Specify only highest grade completed)

Alexander Gunter Agthe

Alexander G. Agthe/Father

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type. Print)

Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. g physician and as the burial-trans within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director,

Milliace I. M	plications that caused the death. Do no	6009Ha	rford Road	l,Baltimo	re, Mary	/land21214	
snock, or neart failure. List only	one cause on each line.			1		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death)	a. Duè to (or as a consequence o		mouture	.ty			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):  Due to (or as a consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant conditions  Chum Mi	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pres			23d. Date of del Month	ivery Day Year	
Part II. Other significant conditions	contributing to death but not resulting in	the underlying ca	use given in Part I.	23e. Did tobacco	use contribute to	the cause of death?	
chemini l	renny			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 🗌 Unknown	
	<u> </u>			24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of	
25. Was case referred to medical			26. Place of Deatl	h (Check only one)			
examiner? 1  Yes 2 No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 ☐ Other (Spec	cify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	ime of 280 njury M	: Injury at Work? 1  Yes 2  No	28d. Describe how in	ury occurred		
3 ☐ Suicide 6 ☐ Could not determined		m, street, factory, o	ffice	28f. Location (Street City or Town, Star	and Number or Ri te)	ural Route Number,	
	Physician: To the best of my knowledge, aminer: On the basis of examination and manner stated.						
29b. Signature and title of certifier	Sittour	29c. L	icense number		Date signed (Monti	h, Day, Year)	

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

infant

20b. Place of Disposition (Name of cemetery, crematory or other p

Reg. No.

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

infant

20c. Location - City or Town, State

600 North Wolfe St, Baltimore, MD, 21287

Rus\$ian<sub>8-25-0</sub>9 Elkridge,Maryland

18. Mother's Name (First, Middle, Maiden Surname)

306West Franklin StreetAPT.503, Baltimore, MD.

OrthodoxmeCemeterymy Marzullo Funeral Chapel, p. A

Noti 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Efrosina\_

S.A.

3. Time of Death

Maryland

1X Yes 2 □ No

10d. Inside City Limits

0:05

Birthplace (State or Foreign Country)

DHMH 17 Rev 1/2001

State

Registrar

Jally

31. Date filed (Month, Day, Year)

racks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per the 895 9-11-09 WS
State of Maryland Department of Health and Mental Hygiene 56 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Montl OS Year **Physician** 2009 1:40 PM 4 Mary C. Butt /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union M emorial Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 X F 74 September 25,1934 Maryland **Director** Usual Residence of Decedent I0d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Experience in set to notified at 1 ☐ Yes 2X No Director Perry Hall Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 USA 4506 Forge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 X Married 1 ∐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Je filed wh. It Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Parks & Recreation Secretary if Health and Mental Hygintem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Caroline Leilich Joseph S. Boddiford ဂ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Spouse 4506 Forge Road Perry Hall, Md. 21128 Leonard B. Butt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of I Important: If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-28-2009 Baltimore City Gardens of Faith Funeral Home Schimunek 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 DAYS MITRAL REGULGITTATTON **Physician** VALUE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of). P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) ned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No certificate 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this y filled in by the funeral di 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 5 Pending investigation (Month, Day, Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 🚰 🗬 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funel completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08/24/2009 RESTOENT PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar SIRA

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

DUSON; 210 EAST UNIVERSITY PARKWAY; BATIMORE, MD 21218

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08-21-2009 Year Physician 348 P Anastasia E. Bell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford 1407 Unit K Bonnett Place Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 11-05-1929 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6 Sex Months Days Hours 1 □ M 2 🕶 F Yrs 79 220-24-4447 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2 ☐ No Director Harford Bel Air MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 1407 Unit K Bonnett Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0.S.I. Federal Employee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Stamobli Harry Economides ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1407 Unit K Bonnett Place Bel Air, MD 21014 Charles Bell Sr (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-26-2009 Baltimore, MD Gardens of Faith 22. Name and Address of Facility Schimunek Funeral Home of BelAir A Funeral Service Licensee 21. Signature Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · ARTERIOSCLERUTIC CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☑No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPER TENSION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manger of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Physician /Medical Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "national".

burial-trar Division of Vital Records, P.O. Box 68760%the as attending for use signed t has

page 2 should To the Hospital or Attending Physician; The funeral director, this After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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State Registrar

ABHYANKA 31. Date filed (Month, Day, Year)

6 ☐ Could not be

MD

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

AVE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BEL AR

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

3 T Suicide 4 Homicide

29b. Signature and title of certifler

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Taheera Brown 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 24, 2009 1230 hrs Medical Examiner Taheera Rashidah Brown 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore 1900 Madison Avenue N/A 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In vrs. last birthday) **Funeral** 5. Social Security Number 6. Sex Foreign Days Hours Min 215-96-3198 Months Director 28 1 Country Maryland 25, 198 1 M 2 X F Yrs Jan. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County N/A Yes 2 No f show Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ۵ 21217 1900 Madison Funeral 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 2 X No Yes Black Specify Yes 2 X No specify: If Yes, Give Year δ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. other than " the Medical I Baltimore, MD 21215-0036 C and S Warehouse Year Selector 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Tanara Ferrell Be Allen James Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2\,5\,4\,0\,4$ 19a. Informant's Name/Relationship (Type, Print) Tanara Powell/ Mother 48 Mossey Lane Martinsburg, West item 27 Virq<u>inia</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 8/27/09 t: If i 1 Burial 2 X Cremation 3 Removal from State Greenmount Cemeterly Baltimore, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility 22 Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licenses the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart only one cause on each line. Approximate Interval Physician 23a Part I. Enter Between Onset and failure. List only one cause on each line /Medical Death Probable acute lamotringe intoxication Immediate Cause (Final disease **F**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and sician/Medical AMENDED 23a, 27, 28a-f, per ME g896 10/1/09 TT TT TE G898 12/8/09 TT X UNPENDED attending physician or use as the burial requires that the death certificate be Box 68760. 23d Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown CHronic alcoholism Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A Certification 1X Natural 1 Yes 2 XN Fd 8/24/09 Fd 12:10 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1900 Madison Ave Ballindre, Mi) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide found at residence determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 25, 2009 -ee 5 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 28 20 Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

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**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a,25,27,28a-f\_per me g894,08/27/09dhb

Reg. No. Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 29, 2009 Year SAMUEL J. BADGER 6:00 P 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery SHADYGROVE ADVENTIST HOSPITAL Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 8, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Hours Min Months 220-07-2555 1 ▼ M 2 □ F Virginia 89 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Gaithersburg Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 217 Booth St., Apt. 334 A USA 20878 Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 🕱 Yes 2 🗌 No If Yes, Give 1 ☐ Yes 2 🛛 No Specify: White WW 2 3 Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use relired) Business Analyst and Contracting Officer 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Goddard Space Flight College (1-4or 5+) Elementary/Secondary (0-12) Center 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arinthia J. Bundick Levin Francis Badger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Glazebrook Court, Gaithersburg, Maryland 20878 Janet F. Badger (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 Kevin E Ecker Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Head Injuries with Complications**Immediate Cause (Final disease or condition disease or condition resulting in death) NIPPLAN TITUS Due to (or as a consequence of): Subdural Hematema Week Due to (or as a consequence of): MEDICAL EXAMINER -Dilated cardiamyopathy months CERTIFICATION Due to (or as a consequence of): If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 X Yes 2 1.40

**Physician** /Medical Examine Examine

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Box 68760.

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Division of Vital

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10a. State

Director

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**Funeral** 

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment must be recitived at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It's Mental Injury or other traumatic event, It's Men

within 72 hours after

Maryland 21215-0036

Baltimore,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

**X-Na**tural

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred Probable Multiple Falls

20850

28f Location (Street and Number or Rural Route Number, FOUND Town, State) 217 Booth Street, Apt. 334A, Gaithersburg, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 XNo

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jawad Arshad, M.D. 9901 Medical CEnter Drive, Rockville, Maryland

28a. Date of Injury
Found, Day, Year)
07/16/2009

and manner stated.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be

Registrar DHMH 17 Rev 1/2001

State

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Home

28b. Time of

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	72 hours after death with the Maryland hatural", or items 23a or 28a-f show dignt Evander out be redfled at	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		i. 13. \	Vas Deceder f Yes, specify	t of Hisp	anic Orig	gin? (Speci	fy Yes or No	0-	14. Race - A Black, W	merican India	n,
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the aftending physi completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the formula for the funeral director and for the funeral director as the formula for the function of the formula for the function of the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At hon	ne, farm, stre	et, factory, o	fice		28		(Street and		r Rural Route	Number,
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1:1000 August 2009 Albert E. Brown Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Baltimore Towson 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Aug. 23 Months Hours Min. 1 □xM 2 □ F , 1951 218-56-1608 MD Director 58 Usual Residence of Decedent shov 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1X Yes 2 No 10e, Street and Number 10f, Zip Code 10g, Citizen of What Country? Funeral 21211 3645 Keswick Road USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ XIIo If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction Painter 8th permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Preston Albert F. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3119 Woodhome Avenue Baltimore MD 21234 Sherry Strausser /daughtet 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 8/28/09 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Mal Home of Essex 21221 MD Connelly Funeral Home of blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or com Approximate Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physiciani Conce months disease or condition resulting in death) -una Medical Due to (or as nsequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown p signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Xyes 2 No 3 Probably 4 Unknown been signated 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed Yes 2 certificate 1 Yes 2 No the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{X} \) Other (Specify) \( \text{Gillows} \) \( \text{Closs} \) \( \text{T} \) 2×2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 A Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be within 24 hours after deat to the Funeral Director: completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 Angust 27. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marian Grant Towson, MD 31. Date filed (Month, Day, Year) State Registrar AUG 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 2:30 P.M Howard Newton Brooks August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Social Security Number Funeral Year) 1929 Min 1 🛛 M 2 🗆 F Vermont Director 026-26-3993 80 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 28a-f s 1 ¥ Yes 2 □ No Maryland Harford Aberdeen 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral USA 21001 548 Bonnie Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by "natural", or **Maryland 21215-0036** 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Yard and Shop Manager Lumber Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanley Ernest Brooks Vera Mace Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a 548 Bonnie Drive, Aberdeen, MD 21001 Patricia N. Brooks / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-09 Aberdeen, Maryland Harford Memorial Gdn. 4 ☐ Donation 5 ☐ Other (Specify) HOUSE Fundance <sup>22</sup>, Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingo 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CELLULITIS, LEG Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or ilnjury ISCHEMIC GANGRENE, LEG attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of resulting in death) Last PERIPHERAL ARTERIAL DISCASE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PSEUDO MEMBRANOUS Hospital or Attending Physician: The law requires 1 24 hours after death. COLITIS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, PULMONARY INTERSTITIAL FIBROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 DIAPPETER, TYPE 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minimal distributions.

☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Andrew Nowalands Mo D08096 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW NOWAKOW SER MD 35 FULFORD AVE BELAIR, NO 2/014 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

eborah Caldwell	State of Maryland /	Department of Health and Me Certificate of Death	ntal Hygiene Reg. No. 2009 27	57
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	Octanoate of Dodan	2 Date of Death 3. Time of Death	
Medical Examiner		Caldwell	August 23, 2009 2243 1115	
	4a. Facility Name (if not institution, give street and number)  Johns Hopkins Bayview Medical Center	4b. City, Town, or Location Baltimore		
Funeral Director	5. Social Security Number 6. Sex 7. Age 1212-78-6564 1 M 2 X F	(In yrs. last birthday)   If Under 1 Year   If U	ander 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Forcing Min. November 15, 1959 Maryland	oreign
any	Usual Residence of Decedent  10a. State 10b. County 1	0c. City, Town or Location	10d. Inside City Li	
<b>8</b> .	Maryland Harford	Havre De Grace	1 Yes 2	No
the Maryland a or 28a-f show tified at once. Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
th the 23a or notifie	458 Green Street  11. Marital Status 12. Was Decedent E	21078 Ever in U.S. 13. Was Decedent of Hispanic Co	USA  Drigin? ( Specify Yes or No-  14. Race - American Indian, Black,	
or items 23 must be no	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexic	an, Puerto Rican, etc.) White, etc.	
s after d	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No spec		
2 hours af "natural Examin		during most of working life. DO No		
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once e Completed by Funeral Director	11 years	Customer Account	Representative Electronics	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple	17. Tatrier S Marite (1 115t) Mindalo, 255t)		her's Name (First, Middle, Maiden Surname) tricia M. Lewis	
e, MD 21215-0036 I and 2 should be filted within 77 Health and Mental Hygiene item 27 is marked other than r traumatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and I	Number or Rural Route Number, City or Town, State, Zip Code)	
MD id 2 sho lith and im 27 is	Ronald Hlopak Father	515 Gleanings Dr.  20b. Place of Disposition (Name of cemetery,	ive, McHenry, Maryland 21541  Date 20c. Location - City or Town, State	
<u> </u>	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta  4 Donation 5 Other Specify:		August 28, 2009 Baltimore, Marylan	d
Baltimo permit. Pages Department of Important: I	21 Signature of Funeral Service Licensee	22. Name and Address of Far Connelly Fune	ral Home of Dundalk, P.A. Point Road, Dundalk, Maryland 2	1 222
Physician	23a. Part I. Enter the dileast, or complications that caused	the lea h. Do not enter the mode of dying, such a	as cardiac or respiratory arrest, shock, or heart Between Onse	nterval
/Medical			sease complicating aortic	Xuiid
xaminer	or condition resulting in death)  Due to (or as a conse	quence of): Insufficiency		
<u> </u>	Sequentially list conditions,	quence of):		
ted Sominer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	quence of):		一
and transit		I line a-b, 27,per ME	g895 9/21/09 TT	-
O, e be execui ysician and burial - tra	AUNTENDED		23d. Date of delivery	
OX 6876 ath certificate attending phy or use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcon	2 Fetal death 3 Ec	topic pregnancy Month Day Yea	ar
Sox 6876( leath certificate e attending phy for use as the bree	1 Yes 2 No 9 ✓ Unknown 9 Unknown	time of death 5 Other (Specify)		
that the der		but not resulting in the underlying cause given i		
S, P.C			1 Yes 2 No 3 Probably 4 ✔ Unk  24a. Was an 24b. Were autopsy findings av	
Records, I The law requires ficate has been sign page 2 should be			autopsy prior to completion of cau performed? death?	use of
Rec The liftcate l		26 Place of D	eath (Check only one)	No
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of Ving Physical distribution of Transfer this control distribution of		28b. Time of Injury 28c. Injury at Veer	Work? 28d. Describe how injury occurred  No	
Sion Attendideath. death. ector:	Natural 5 Pending 2 Accident Investigation	njury - At home, farm, street, factory, office building		er, City
Division o spital or Attending hours after death erral Director: After filled in by the fune	3 Suicide 6 Could not be determined (Specify)	ijury - Actionic, iann, ocooc, ioccory, ocioc ballan	or Town, State)	
	(Check only one) 2 Medical Examiner: On the best of recommendation one)	ly knowledge, death occurred at the time, date ar mination and/or investigation, in my opinion, dea	nd place, and due to the cause(s) and manner as stated.  th occurred at the time, date and place, and due to the cause(s)	
To To com	and manner stated.  29b. Signature and title of certifier	29c. License nur		
	(a/111-11)	O.C.M.E	. August 24, 2009	
9	30. Name and address of person who completed cause of a Zabiullah Ali, M.D. Assistant Medical E		re, MD 21201	
Sta	2 31. Date filed (Month, Day, Year) 32. Registra	ar's Signature		
Registr	AUG 20 2000 COM	ORIGINAL	OCME	-
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09-06645 Michael Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ichael Cox	1.	State State	of Maryland /		nent of l cate of i		d Mental Hy		No	200	9 2757
Physician	R	egistrar . Decedent's Name (First, Middle,La	ast)	Certine		Douth		Reg. 2. Date of Death			3. Time of Death
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	4	a. Facility Name (if not institution, gi	ive street and number)		41	. City, Town, or Baltimore	Location of Death		4c. Cour	nty of Death	
Funeral	5	•	Sex 7. Age	(In yrs. last bi	irthday)	If Under 1 Yea		-		Eoroige	nplace (State or
Director		212 48 1271	X м 2 F	63	Yrs.	Months Day	s Hours Min.	08/13/	1946	Cou	Intry)Virginia
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Aaryland 28a-f show 1 at once.	01	Oe. Street and Number				10f. Zip Code		109	. Citizen of	f What Coun	
the M		1005 Quantril Wa				212			15	USA	
5-0036   filed within 72 hours after death with the Maryland   Hygiene,   A other than "natural", or items 23a or 28a-f she   the Medical Examiner must be notified at once.	leral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent E Armed Forces?	•	13. Was	Decedent of Hiss s, specify Cuba	spanic Origin? ( Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		Vhite, etc.	can Indian, Black,
ter dea	리		ed If Yes, Give Year	No	1	Yes 2 X No	specify:		Spec		nite
ours af	g P	15. Decedent's Education (Specify	only highest grade com-	pleted) 16a	a. Decedent	's Usual Occupa	ation (Give kind of ve. DO NOT use reti		16b. Kind o	of Business/li	ndustry
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5-0036 led within 72 hours af type of the within 12 hours af type of the within "matural to the Medical Examin	Completed	12 17. Father's Name (First, Middle, La	lst)		Fac	tory Wo	18.Mother's Name	(First, Middle, M			company
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e, MD I and 2 sho Health and item 27 is		James M. Cox (br	other)	20b. Plac		ition (Name of co		Date	20c. Local	tion - City or	Town, State
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental I Important: If item 27 is marked injury or other traumatic event,		1 XBurial 2 Cremation	3 Removal from Sta	te cren	natory or oth	ner place) Mem <sub>=</sub> (-	ardens 8	/28/2009	Midd	lle Ri	ver, Marylan
Iltim nit. Pa artmer ortani	ŀ	Donation 5 Other Spec  2 Donation 5 Other Spec		11011	22. N	ame and Addres	ss of Facility Br	uzdzinsk	i Fur	eral J	Home PA
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Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed as alreads.  al Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED	dAMENDED								
60, ate be	Med	IF FEMALE:	23c. If yes, outcor	me of pregnar	ncy					ate of delive	
687 certific	ian/	23b. Was decedent pregnant in the past 12 months?	The second second	time of death	-	etal death 3 ther (Specify)	Ectopic pregr	nancy	Mo	ntn	Day Year
, P.O. Box 6876 rices that the death certificate signed by the attending phybe deached for use as the	Physician/M	1 Yes 2 No 9 Unkno	own g unknown		<u> </u>						the same of death?
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tal Recolcian: The law certificate has		25. Was case referred to medical				26.Pla	ace of Death (Chec		2 / No		Yes 2 No
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n of Vital Records, ling Physician: The law required After this certificate has been if funeral director, page 2 should		27. Manner of Death	28a. Date of Inj (Month, Day, FOUND:	ury 2 Year) 2	8b. Time of	Injury 28c. II	njury at Work?	28d. Describe Unknown	how injury	occurred	
Sion ttendi death. ctor:	atio	1 Natural 5 Pendir 2 Accident Investi	igation Aug 25, 2009	9 (	0525 hrs	eet, factory, offic	Yes 2 No	28f Location (	Street and	Number or f	Rural Route Number, City
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To the Hospi within 24 hou To the Funer completely fi	Medical	one) 2 Medical Exam	niner: On the basis of exa and manner stated		d/or investiga			d at the time, date			Month, Day, Year)
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		(Aportar)	ew)	death (Itom 3	23a)						
		30. Name and address of person v Laron Locke MD. As	who completed cause of ssistant Medical Ex	caminer	111 Pen	n Street, Ba	ltimore, MD 2	1201			
	tate		- An	ar's Signature	par	Kal					
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		- For State		Certif	icate of	Death			Reg	. No.	000 -101
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	4	4a. Facility Name (if not instituti Sinai Hospital	on, give street and nur	nber)	4	b. City, Town, or I Baltimore	ocation of	f Death		4c. County o	of Death
Ermount	s	5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under	r 24Hrs. 8.	Date of Birth	(MM/DD/YYYY	9. Birthplace (State or
Funeral Director		245 <b>-</b> 45 <b>-</b> 8573	1 X M 2 F	25	Yrs. Months Days Hours Min. 05					84	Foreign Country) MD
	Ţ	Usual Residence of Decedent									
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hours	3	15. Decedent's Education (Sp				t's Usual Occupati ost of working life.			done	16b. Kind of Bu	usiness/Industry
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within 7: within 7: within 7: Medical	┋┝	17. Father's Name (First, Middle						's Name (Fir	st. Middle. M	aiden Surname	
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21215-0036 ould be filed within 7 Mental Hygiene.  8 Manked officer than the event, the Medica		19a. Informant's Name/Relation			19b. Mailing	Address (Stree				oer, City or Tow	vn, State, Zip Code)
MD at 2 sho alth and m 27 is aumath	-	Sandra Dean	s-Mother		5051	Pembri	dge	Ave,	Balt	imore	, Md 21215
10re, MD 21215-0036  gges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygene. 1. If them 271s marked other than "natural", or items 23a or 28a-f sho other traumatte event, the Medical Examiner must be notified at once.	t	20a. Method of Disposition			ice of Dispos	ition (Name of cer	netery,	Da	ate	20c. Location	- City or Town, State
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene important, or items 23a or 28a-f she injury or other traumatte event, the Medical Examiner must be notified at once To De Completed by Eurogral Director		1 Burial 2 X Crematic		JIII State	n-Sit			8/30/	/09	Balti	more, Md
Baltimo	+	4 Donation 5 Other 3 21. Signature of Funeral Service		`	22 N	Jame and Address	of Eacility	/			
Dep De liji		Blad	w w	ane	143	rch F/H 00 Waba	ash A	Ave,	Balti	imore,	Md 21215
Physician	1	23a. Part I. Enter the disease, of failure. List only one caus	or complications that ca	aused the death. D	o not enter t	he mode of dying,	such as ca	ardiac or res	piratory arre	st, shock, or he	eart Approximate Interval Between Onset and
/Medical xaminer	1	Immediate Cause (Final diseas	se a. Gunshot W	ounds (2) of H	lead and	Neck					Death
ханны	-	or condition resulting in death)	Due to (or as a	consequence of):							
	۱.	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence of):							
	H	cause. Enter Underlying Caus (Disease or injury that initiated	с								
ted Insit	Z L	events resulting in death) Last	Due to (or as a	consequence of):							
tox 68760, eath certificate be executed attending physician and for use as the burial - transit	3	UNPENDED	d								
se be c	5	IF FEMALE:		outcome of pregna	IDCV			475		23d. Date o	of delivery
876 tifical ng ph		23b. Was decedent pregnant in				etal death 3	Ectopic	c pregnancy		Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	Sicial	past 12 months?  1 Yes 2 No 9 U	lak neuva	ant at time of deat	la 🗆	ther (Specify)				1913	
Bc dear the a	7		nknown g Unkno			As I de conse	duranta Da		Laso Did to	hacco uso cont	tribute to the cause of death?
sords, P.O. B law requires that the d has been signed by the 2 should be detached	2	Part II. Other significant cond	ittions contributing to	o death but not res	uiting in the	underlying cause g	given in Pa	art i.			Probably 4 Unknown
S, I									24a. Was a		Were autopsy findings available
Ord aw red as be 2 shou	Completed								autop	sy	prior to completion of cause of death?
tal Reco	<u> </u>								1 🗸 Yes		1 Yes 2 No
tor,	o l	25. Was case referred to media examiner?				26.Place		(Check only			
this of life in this of life i		1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🗸 E			Other <sub>4</sub>	Nursing H		Residence 6	Other:
1 Of ling Pl After funera		27. Manner of Death  1 Natural 5 Po	28a. Date (Monti Aug 20	Day Year)	28b. Time of 0141 hrs		iry at Work	- ISu	d. Describe i ibject sho	now injury occur t	rred
IVISION or Attend after death Director:	Ĭ		estigation				Yes 2 ✓			N	han as Dural Davida Number City
lor A after Dire	Certification:	de	ould not be	e of Injury - At hom		et, factory, office	ouilaing, e	itc. 28	or Town, S	street and Num tate)	ber or Rural Route Number, City e, Baltimore, MD
ospita hours ineral		4 V Homicide	(op cony)	Local Street							
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivation of the Funeral Brac death.  Completely filled in by the funeral director, page 2 should be detached for use as	Medical		Physician: To the best	of examination and	e, death occu d/or investiga	irred at the time, d ation, in my opinio	ate and pi n, death o	ace, and du ccurred at th	e to the caus ie time, date	e(s) and manne and place, and	due to the cause(s)
To with Con	Ĭ.	29b. Signature and title of certi	and manner s	stated.		29c. Licens					ned (Month, Day, Year)
		Dung	) INV			O.C.	M.E.			August 20	), 2009
	}	30. Name and address of person	on who completed cau	se of death (Item 2	?3a)					1	
		Donna M. Vincenti, I		Medical Exami	iner 11	1 Penn Street	t, Baltim	ore, MD	21201		
Sta Registra	_	31. Date filed (Month, Day, Yea	324R	egistrar's Signatu	pa	Red					
V-16115111	-11	IATILL COL	1 CHULL VIII		- #						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g894 8-28-09 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 5:15 AM August Ronald Gerald Davis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2709 Anderson Road White Hall **Baltimore** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 16, 1934 Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Months 1 M 2 □ F Pennsylvania Director 204-26-2623 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar roust be notified at MD White Hall 1 ☐ Yes 2 🕱 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21161 2709 Anderson Road death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐Yes 2√2 No Specify. white \$ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Facilities Engineer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ft.Dix. NJ 12 Pages 1 and 2 should be filed vent of Health and Mental Hygint; if Item 27 is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 1s marked any injury or other traumatic evonce. UNKNOWN Mary Richard Davis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Anderson Road-White Hall, Maryland Fern Davis-spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Charcel and Chematican Services belair 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Sept.1,2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16924 York Road Chapel Services Evans Funeral and Cremation Monkton, Maryland 21111 LTV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Head Immediate Cause (Final **Physician** disease or condition resulting in death) and /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ∏Yes 2 ∏No 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Matural 2 ☐ Accident 5 ☐ Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00067414 30. Imme and address of person who completed cause of death (Item 23a) (Type, Print) 10 Richmon 601 N. 31. Date filed (Month, Day, Year) \_\_\_\_\_32. Regist State Registrar

DHMH 17 Rev 1/2001

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:14 P M 0 DOSTER AUGUST 25 2009 SHIRLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HORKING BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Z-Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Days Hours 1 □ M 2 🕩 MD 4-50-455 01-24-1941 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Director Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21224 Funeral 7258 Stratton Way 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White \$ 3 ☐ Widowed 4 Mivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Retail Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Pizlo Chester Olszewski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7258 Stratton Way Baltimore, MD 21224 Amy Doster/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 08.27.09 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee P.A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 DAY BOWEL TERFORATED Due to (or as a consequence of): 1 YEAR METASTATIC COLUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusite (or as a consequence of): Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 **V**No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Ma

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

and burial-trar physician the as attending asn for

signed I page 2 should After this certificate I funeral director, page

Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the I

> State Registrar

DHMH 17 Rev 1/2001

Medical

27. Manner of Death

1 Natural

2 Accident 3 🗌 Suicide

4 Homicide

29b. Signature and title of certifie

MARC LAROCHELLE M.D. 31. Date filed (Month, Day, Year)

AUG 28 2000

29a. Certifier (Check only one) 5 Pending investigation

6 Could not be determined

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4940 EASTERN AVENUE BALTIMORE, MD 21224

29c. License number

RES -000

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUGUST

29d. Date signed (Month, Day, Year)

25, 2009

28a. Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

Davis Sr.

2. Date of Death

AUGUST

Day

Year

2009

U.S.A.

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 26, 2009

Specify:

14. Race - American Indian,

Black

Black, White, etc.

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

4:45 PM

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

4 HOURS

5 years

Year

1 XYes 2 No

Ford

State Registrar

Medical

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

1 - For State Registrar

Henry

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

SHAILENDRA SINGH 31. Date filed (Month, Day, Year) AUG 2 8 2009

Shoulendra Jun

6 ☐ Could not be

SINAI MID 3. Registrar's Signature

M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE HOSPITAL OF

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES - 000

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24 hours after death e Funeral Director:

within 2

the Hospital or

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Sparks 130/11more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 F 341-07-9846 Usual Residence of Decedent North Yrs **Director** 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercitival included by confined at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: WNIT 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than College (1-4or 5+) Elementary/Sącondary (0-12) Dendix 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Pages 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee orked. Monkton, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as + consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) □Yes 2No signed by the a o. 9 Unknown 9 Unknown <u>.</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ No No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospital or Attending Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director A investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite Nomisville Kd Year) 31. Date filed (Mont State 28 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year DEGROAT 15 AM AUGUST 2009 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SQUARE HOSP27AL 1-RANKLIN BAL TIMORE Baltimore 8. Date of Birth (Month, Day, Year) July 7, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days 1 ☐ M 2 ☐ XF 215-34-2140 70 TN Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 ☐Yes 2 No MD Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 26 Tea Rose Drive 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KINNIE Holden Rosie Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark DeGroat /son 3170 Maple Leaf Drive Lexington KY 40509 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20c. Location - City or Town, State 20a. Method of Disposition Holly Hill Cemetery 8/27/09 Baltimore MD 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 MAce Ave. Balto. MD Essex 21221 Connelly Funeral Home of Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, UNKNOWN

**Physician** /Medical

**Physician** 

/Medical

Examiner

Funeral Director

2

Be Completed

ပ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified an once.

Baltimore, Maryland 21215-0036

**Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed

after death Director:

Division of Vital Records, P.O. Box 68760;

	shock, or heart failure. List or	ily one cause on each ling.		Onset and Death
	Immediate Cause (Final disease or condition	NON ITODUKTOS LYMPHOMA		UNKNOWN
	resulting in death)	Due to (or as a consequence of):		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		
cam	Cause (Disease or injury that initiated events resulting in death) Last	c		
<u>س</u>	resulting in death) cast	Due to (or as a consequence or):		
edic	23.	d		
ıysıcıan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4  Pregnant at time of death 9 Unknown	23d. Date of d Month	elivery Day Year
a by Pr	Part II. Other significant condition	o on an industrial to death but not receiving in the analysing eached given in tart in		to the cause of death? Probably 4 🗌 Unknown
complete		24a. Was an autopsy perform 1 □ Yes 2	ed?   death?	autopsy findings available completion of cause of es 2 UNo
ge (	25. Was case referred to medical examiner?	26. Place of Death (Check only one	) 1	
		11		

State Registrar

within 24 hours a

To the Funeral D

Medical Certification: To

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

8-24-2009

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70+10 / 10-17 427 H2C MD SQUARE FRANKLIN

DRIVE, BALTIMORE

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

32 Registrar's Signature

1 Depatient

Date of Injury (Month, Day, Year)

5 Pending investigation

6 Could not be determined

2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** James E. DeGroat 24 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Roseda 8. Date of Birth (Month, Day, Year)
May 11,1935 Birthplace (State or Foreign Country) If Under 24 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Min 1 🔀 M 2 🗆 F 74 237-48-4655 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be nutified at any injury or other traumatic event, the Medical Evantiner must be nutified at any injury or other traumatic event. 1 ☐Yes 2 ☐ No Director Baltimore Middle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 26 Tea Rose Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify. Specify: White ⋧ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Supervisor Logistics 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( . Pages 1 and 2 should be fill iment of Health and Mental Htant; If item 27 is marked oth James H. DeGroat Pearl Pittman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Mark DeGroat 3170 Maple Leaf Drive Lexington KY 40509 /son 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 8/27/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 300 Mace Ave. Balto. Funeral Home of Essex MD 21221 attic Connelly 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed Monja burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the t for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 1 ☐Yes 2 No 2 No ∐Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 124 hours after death.

In Funeral Director: A setely filled in by the funeral by the funeral filled in by the funeral filled in by the funeral filled in by the funeral funeral funeral funeral funeral funeral funeral fun 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin 000 Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

AUG 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Aug. 21, 2009 Martha E. Deskin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Woodlands Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 8,1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 216-40-1587 1 □ M 2 □XF AVW Director 83 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Middle River Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 21220 USA 1500 Chilworth Avenue items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify. þ White 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within Hygiene. is marked other than Elementary/Secondary (0-12) Coilege (1-4or 5+) own home Homemaker 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked othe any Injury or other traumatic manners. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Goldie C. Hoke Grove L. Lucas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Chilworth Avenue Baltimore MD 21220 /son Dan Deskin 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 8/25/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Saute Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 Do not enter the mode of dying, such as cardiac or respiratory a rest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of) Examiner ON ON Sequentially list conditions, dany, Isaair g to in media cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of): burial physician s the burial Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ned by the a o 9 Unknown signed by t the detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe ate h 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 DXNo Division of Vital Physician certifi rector, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (See 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the north within 24 hours after death.

To the Funeral Director: Af To the Hospital

State

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one) 29b. Signature and title

ess of person who co

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ble. 2009 2758.

nan Evans		I- For State Certification Certification	icate of Death		Reg. N	0.	
Physicia	_	1. Decedent's Name (First, Middle,Last)			Date of Death  Month  Da	y Year	3. Time of Death 1436 hrs
edical Examir		Nolan Lamont Evans		Location of Death	August 25, 20	4c. County of Deat	
	•	Facility Name (if not institution, give street and number)     Sinal Hospital	Baltimore	Focation of Death		N/A	
Funant			birthday) If Under 1 Yea	If Under 24Hrs.	8. Date of Birth(N	- 1/	rthplace (State or
Funeral Director	L	220-90-2924 212-30-3949 1xxm 2 F 40	Yrs. Months Day	/s Hours Min.	July 1	6, 1969	rthplace (State or gn buntry) Maryland 
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
<u> </u>		Maryland Baltimore Mil	ford Mill				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	untry?
the M a or 2 tified		3721 Washington Avenue	212			USA	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f. sho matic event, the Medical Examiner must be notified at once.	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Ongin? (Spon, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
or ite	Funeral	XNever Married 2 Married 1 Yes 2 X No	1 Yes 2X N			Specify: B	lack
s after	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 1	6a. Decedent's Usual Occupa	ation (Give kind of w		b. Kind of Business	
2 hours at "natural	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life	e. DO NOT use retir	ed)		
336 thin 7 re. than	힐		Laborer				Industry
215-0036 be filed within 72 ntal Hygiene. rked other than '	ပ	17. Father's Name (First, Middle, Last)		18. Mother's Name			
21215-003 buld be filed within Mental Hygiene. marked other ti	B	Vernon Evans	19b. Mailing Address (Stre	Gwend	olyn Ge	ter r City or Town, Sta	te. Zip Code)
imore, MD 2121. Pages I and 2 should be firment of Health and Mental I tant: If item 27 is marked or other traumatic event,	۴	19a. Informant's Name/Relationship (Type, Print) Grandmoth Joyce M. Gardner/	er 1 3721 Wash	inaton	Avenue	Milford	21244 Mill,MD
MD and 2 sho ealth and tem 27 is	-	20a. Method of Disposition 20b. Pta	ace of Disposition (Name of c		Date 2	0c. Location - City	or Town, State
IOFE ges 1 It of H It If i		Burial 2 Cremation 3 Removal from State	ematory or other place) Zion Cemet	0711 8/	29/09	anedown	e.Maryland
Baltimore, MD 2 pernit Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic	1	4 Donation 5 Other Specify: MIC •	22. Name and Addre	ee of Facility			uneral Hom
Den Den Ba	j	23a Part I. Enter the disease, or complications that caused the death. I	\$240 Reis	torstow	n Road	Baltimo	re MD 2121
Physician	9	23a Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter the mode of dyin	g, such as cardiac o	r respiratory arrest	, shock, or heart	
/Medical vaminer	- 1	Immediate Cause (Final disease a. Multiple Gunshot Wound					Death
tallillo.		or condition resulting in death)  Due to (or as a consequence of):			•		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examine	(Disease or injury that initiated events resulting in (death). Last events resulting in (death). Last					
ited d ansit		d					
50, te be executed ysician and burial - transit	Medical	UNPENDED X AMENDED #5, per	Inf G895 9/3	0/09 TT			
'60, zate be physic he bur	Med	IF FEMALE: 23c. If yes, outcome of pregn.	ancy			23d. Date of deli	very Day Year
Sox 687 leath certific e attending   for use as th	sician/	23b. Was decedent pregnant in the past 12 months?	_	3 Ectopic pregn	ancy	Month	Day Tour
Box 687 death certific the attending p	ysic	1 Ves 2 No 9 Unknown	5 Other (Opecay)				
that the d	/ Phys		sulting in the underlying caus	e given in Part I.			e to the cause of death?  Probably 4 Unknown
, P.O.	d by						autopsy findings available
rds v requisional	Completed				24a. Was ar autops perform	y prior	to completion of cause of
ecc he lav ate har	ᄩ				1 Yes 2		
Vital Rec sysician: The this certificate I director, page	ပ္က	25. Was case referred to medical		ace of Death (Check			Alexander and a second a second and cond and
Vita hysici this c	TO B	1 Yes 2 No 1 Inpatient 2	ER/Outpatient 3 DOA	Other Nursi		tesidence 6 Cow injury occurred	ther:
Ing P	<u>`</u> ;;			Yes 2 ✓ No	Subject shot	, w mjary boodea	
Siot Attend death cetor:	cati.	2 Accident Investigation	ome, farm, street, factory, office		28f. Location (St	reet and Number o	r Rural Route Number, City
Division of Vital Records, tat or Attending Physician: The law requirms after death.  The Invector After this certificate has been sitted in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify) Sidewalk	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	I or Town St	ate\	rd, Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	S		ge, death occurred at the time	e, date and place, ar	d due to the cause	(s) and manner as	stated.
o the ithin is the omplet	Medical	(Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.			at the time, date a		(Month, Day, Year)
: - :	ž	29b. Signature and title of certifier		ense number		August 26, 20	
		after Grassell, Mo		C.M.E.		, 109431 20, 21	
		30. Name and address of person who completed cause of death (Item Melissa Brassell, MD Assistant Medical Examir		t, Baltimore. MI	21201		
	,,,,						
Regi	tate	111-2871119 /haceas A	. parked				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 08-23-2009 Day Physician 615 Ам Rose Mary Fonte /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Rock Spring Village Bel Air Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 10-17-1914 213-03-3886 94 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director Bel Air MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21015 1408 Bonnett Place #C Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Cinquini Anthony Della Barba ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce. 1408 Bonnett Place #C Bel Air, MD 21015 Jacqueline Heckman (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08-27-2009 Gardens of Faith Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature on Funeral Service Licensee coccle Inc 610 W.MacPhail Rd BEl Air, MD 21014 Approximate Interval Between Onset and Death 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** tailure resulting in death) /Medical Due to (or as a consequence of) Examiner ongestive Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Fibrillation physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. the death certificate be Physician/Medical signed by the attending to be detached for use as IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2♥No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assistat Liv Hospital: 21 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation М 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 e forest HII MD 21050 Colgat 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

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		-	For State	State	of Ma	ryland		artment <i>tificate</i>			and M	lental H		0.0	00	0750	20
		_	Registrar  1. Decedent's Name (First, Middle	Last)			Cer	lincate	OI D	calli		2. Date of D	Reg.	No.		O Time of Doots	
	Physicia	n/										Month	1	Day	Year		.n
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)	Examin	er		-				4b. City, To			n Deam		- 1	4c. County		lace (State or Foreign ny) 21 and 21 and 22 and 23 and 24 and 25 an Indian, 26 an Indian, 27 an Indian, 28 an Indian, 38 an Indian, 39 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 30 an Indian, 31 an Indian, 32 an Indian, 33 an Indian, 34 an Indian, 35 an Indian, 36 an Indian, 36 an Indian, 37 an Indian, 38 an Indian, 38 an Indian, 39 an Indian, 30 an Indi	
			Gilchrist Hos 5. Social Security Number	oice Cer 6. Sex		(In yrs. last	hiethelayl	To If Under 1	WSO1		24 Hrs	8. Date of B	lieble.	<u>B</u>	alto		
	Funeral Director			1 X M 2 □	F		Yrs.		Days	Hours	Min.	(Month, E	Day, Yea		Count	'ry)	ngri
			215-14-9319 Usual Residence of Decedent		8.7	/						May 19	1, 19	//	Mary	/land	-
	and shov	0	10a. State 10b. County			10c. City, T	Town or Loc	ation							1	0d. Inside City Lim	nits
	faryla Ba-f tifiec	ect	Md. Bai	Lto.			N	Nottin	ighar	n						1 ☐ Yes 2X☐	No
	or 2	٥	10e. Street and Number					10f. Zip 0	Code		-		10g.	Citizen of V	What Coun	try?	$\neg$
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	eath tems er mi	Ë	11. Marital Status	12. Was D	ecedent Ev	ver in U.S.	13. V	Vas Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No	)-		e - Americ	an Indian,	$\neg$
9	or if		1 Never Married 2 🔀 Marr		l Forces? ′es 2 □ N Give	∿ Navy		Yes, specif			, Puerto	Rican, etc.)			k, White, e		
ဗ္ဗ	rsaft Iral", Exa	ed	3 Divorced 4 Divorced	If Yes, Year o	Give r Dates.	,	1	☐ Yes 2	X No	Specify:				Specify:	Whit	te	
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anc Sur	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	10 B	17. Father's Name (First, Middle, L	,								(First, Middle	-	en Surname	<del>)</del> )		
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Maryland 21215-0036	4 4 2 2		19a. Informant's Name/Relationsh Marie Franc	ip (Type, Print)	Spous			g Address ( ${f Fow 1}$				Route Numb  Otting					
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~	permit. Page 1 a Department of H Important: If ite any injury or ott		1 Burial 2 Cremation			cem	netery, crem	natory or oth	ner place			Date			•		
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1	Medical Examiner		resulting in death)	Due	to (or as a	consequen	ice of):									0 -	
		ē	Sequentially list conditions,	b. —	t= /== == =										-		-
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7h	ecute and -tran	xaı	that initiated events resulting in death) Last	c. Due	to (or as a	consequen	nce of):									_	$\dashv$
	or Attending Physicians: The law requires that the death certificate be executed after death.  Birector. After this certificate has been signed by the attending physician and lin by the funeral director, page 2 should be detached for use as the burial-transit.	dical					,										
09/	phys the l	edic		d													=
89	ertifik ding se as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome o	of pregnance	y							nod Da	te of delive		
ŏ	ath c atten for u	ciar	in the past 12 months?		ive Birth 2 regnant at		leath 3 🗆 ath 5	Ectopic produced of the control of t								,	
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<u>p</u>	requ	lete	- Panal Bladd	c Can	1							24a. Wa	s an	24b. \	Nere autor	sv findings availab	ble
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ıta	sicia certi irecto	o Be	examiner?  1  Yes 2 No	Hospital:		-1 0 🗆 ==	2/O + !!		Other					. X	10 11	Gildois	
<u>}</u>	r this eral d	e: To	27. Manner of Death	28a. D	ate of injury	y 28	R/Outpatien Bb. Time of		c. Injury			me 5 L Hes 28d. Describe				OUCK!	$\vdash$
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Division of Vital Records,	alor s afte l Dire		4 E Horneldo dolorii	bı	uilding, etc.	(Specify)					Į.	City or To	own, Sta	ite)			- 4
	ospit hour unera	Medical		Physician: To the													
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  Whithin 24 hours after death.  Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Mec	(Check 2 L Medical E	Nurse Praction	er To the b	amination at	na/or invest	lgation, in m	y opinion	tine, Jak	and plac	the time, date	and pla	ice, and due	to the cal	ise(s) and manner s	stated.
	North To t		29b. Signature and title of certifier	4 ,	0 1.6	2		- 1	License		. ^		l 🔥	Date signed			
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	0		30. Name and address of person v						_								
			Marian Gran	1, 630	01 (1)	L. Cha	rles	St.	Tou	١٥٥٠	^,	MD	31	DOY			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** RUTH FELTON 06:12 AM AUG 10 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD COUNT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day 127 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 6. Sex Months Min. 578-32-155 Days Hours 1 □ M 2 🗙 F Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. Coun Town or Location d other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at cott 1 □Yes 2 No Director MD toward 10g. Citizen of What Country? 10e. Street and Number USA oring Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 □Yes 2 1 1 III of the state 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Black Completed by 3 Widowed 4 □ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work dorse during most of working life. DO NOT use relieed) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. sport Processor Jovernment Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, It once. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Informant's Name/Relationship (Type. Plintaughter) 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) arkspring Row Felton-Kedmon 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Pages 1 1≱Burial 2 ☐ Cremation 3 ☐ Removal from State in coln 4 ☐ Donation 5 ☐ Other (Specify) eral Services 21. Signature of Funeral Service License 23a. Part 1. Enterule disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pheumonia Physician Aspiration disease or condition resulting in death) /Medical awork haller Due to (or as a consequence of): Examiner Puspi volosy
use to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last APPROVED BY MEDICAL EXAMINER Examiner be executed burial-tran CERTIFICA Due to (or as a consequence of): P.O. Box 68760, Physician/Medical The law requires that the death certificate the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> Ž No 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy performed? 1 Yes 2 Wo certificate Division of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2√No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation † Natural 2 Accident Probable Fall ithin 24 hours after death.

To the Funeral Director: Air completely filled in by the fu 1 □Yes 2 No unknown unkucren 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Unknown Unknown To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD D0064760 10/2009 Mythilly 30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

State Registrar Mythily VCe
31. Date filed (Month, Day\_Year)

Vourcha

32 Projetrar's Signature

Direct B. Barks

10724 Little Patrixent Reikway, Colembia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 16aper State of Maryland / Department of Health and Mental Hygiene

1- State Amend 10f & 19a-b, per Inf G895 9/9/09 TT

Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician .015 Fauntleroy Dorothy August Marie 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Season's Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Seoprity Number **Funeral** Days Hours Months 1 □ M 2 🔽 F 82 Yrs 219<del>-20</del>-0202 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number <del>21207</del> 21215 U.S.A. 3618 Manchester Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3€ Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Practical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Nurse <del>Assistance</del> Mercy Hospital 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Malone Baker Gid Hugh Williams 19b. Mailing Address (Street and Number or Rural Rouge Alumber Strate, Ongatu-Ibrahima Kassama 2102 Chantilla Road, Baltimore, Md 21207 ·Ongatu Kassama-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important; If ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Garrison Forest 8/31/09 Owings Mills, Md March F/H West |4300 Wabash Ave, 21. Signature of Functal Service Licensee 21215 Comette Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** olon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -tran Due to (or as a consequence of) burial-1 Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No o 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No of Funeral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Kartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2009 H4593/ 30. Name and address of person who completed pause of death (Item 23a) (Type, Print) ton OLD, COURT ROAD Randallstown MD 5400 16001F

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28

Registrar's Signatu

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			For State Registrar	State or Maryl		rtment of F tificate of			giene Reg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, La	vnolds I	7.Hiv	19		2. Date of Dea	Day Year	3. Time of Death  H:42p M
71	Examir		4a. Facility Name (If not institution, girls 2 2 6 800)	1	Antic	4b. City, Town, o	r Location of Death	. 1/0	4c. County of De	ath
	Funeral Director		5. Social Security Number 448-12-1194	Sex 7. Age (In y	vrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Mar 1	th Year) 9. Bi	irthplace (State or Foreign Country) Lafroma
	land ow It		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ation				10d. Inside City Limits
	a-f sh	ctor	MD Baltin	nore	Lutherv	ille Timo	onium			1 □Yes 🌉 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 12261 Roundwood	Rd. Apt. 150	2	10f. Zip Code 21093	3		10g. Citizen of What C United S	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the W. droll Examiner must be notified at		11. Marital Status  1 Never Married 2 Married  3 MX/idowed 4 Sovorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ★ o If Yes, Give Year or Dates:	1	Vas Decedent of H fYes, specify Cub ☐Yes 2☐Mo	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)	14. Race - Am Black, Wh Specify:	
15-0	n 72 ha "natu	Completed by	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	oation during most of work d)	king	16b. Kind of Busines	s/Industry
212	d withir giene. r than	фщо	Elementary/Secondary (0-12)	College (3-4or 5+)	I	anaker	<i>u)</i>		Own Home	
Maryland 2	2 should be filed within h and Mental Hygiene. Is marked other than "raumatic event, the hygiene.	To Be C	17. Father's Name (First, Middle, Lass Clarence Edward:				18. Mother's Nam Eva O		Maiden Surname)	
	1 and 2 short Health and I tem 27 is ma other trauma	ľ	19a. Informant's Name/Relationship Melinda Fitting	/Daughter	139	32 Blenh	eim Road		er, City or Town, State	, Zip Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Contents)	Hemoval from State		sition (Name of natory or other plan ke Crema	i	Date Aug 27, 2009	20c. Location - City of Beltsvill	er Town, State
Bait	permit. Departi Import any inj		21. Signature of Funeral Service Lice	the	L	<u>ohrmann</u>	, PA 87.	17 Gree	<sub>rnatives</sub> /St en Pastur	ephen D. es Dr.
1	Physician /Medical Examiner	0 0	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the drone cause on each line.  a. Due to (or as a cons		er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause cuisease or injury that initiated events	Due to (or as a cons	sequence of):					
68760,	ficate be executed physician and s the burial-transit	ledical Exa	resulting in death) Last	Due to (or as a cons	sequence of):					
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bural-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnand	су		23d. Date of c Month	delivery Day Year
ds, P.	uires that signed by Id be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	/	to the cause of death?  Probably 4  Unknown
of Vital Records,	<b>iclan:</b> The law requii certificate has been s ector, page 2 should	Completed	OF Was and afford to the state of					1 □Yes	psy prior t ormed? death 2 No 1 □ Yo	
Z.	ysiclan: is certific director,	To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatier	t 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H		one) idence 6 □Other (Si	pecify)
n o	ding Phys h. After this funeral dii	on: T	27. Manner o Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury	Woi	ry at rk?		how injury occurred	
Division	Atten deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De Place of Injury A	At home, farm, streecify)		]Yes 2□No	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
<i>p</i>	To the Hospital or I within 24 hours after To the Funeral Direct completely filled in b	Medical Ce		hysician: To the best of my miner: On the basis of exan and manner stated.						
L	To the within To the comple	Med	29b. Signature and title of certifier	Disms	707	29c. Licens	se number	>	29d. Date signed (Mo	onth, Day, Year)
			30. Name and address of person who	completed cause of death (	(Item 23a) (Type,	Print) GOC	N. Wo	lfest.	Bult MD,	21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature			-		
DH	Registr MH 17 Rev 1/2		AUG 28 20	109 Server	D. 40	well				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Veal **Physician** John P. Gargiulo AUGUST 10:05A M 2009 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Min. Months Days Hours 1 X M 2 □ F 85 Director January 3,1924 Maryland 217-16-6148 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐Yes 2 No Director Md. Balto. <u>Nottingham</u> 10g. Citizen of What Country? 10e. Street and Number death with USA 21236 4110 Perry View Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ™ Yes 2 □ No
If Yes, Give
Year or Dates: 1943–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Š Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machinist Bendix 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Louise Balsom ဂ Frank Gargiulo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 9022 Carlisle Avenue Nottingham, Md. 21236 JoAnn Lazzeri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-29-2009 Gardens of Faith Baltimore City, Md. of Funeral Service 22. Name and Address of Facility Schimunek Funeral Home 21. Signatur 9705 Belair Rd. Nottingham, Md. 21236 Pax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CONGESTIVE HEART FAILURE resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE RENAL FAILURE Sequentially list conditions, Due to (or as a consequence of). Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury and PERINEPHRIC HEMATOMA that initiated events resulting in death) Last physician ar Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy õ Month Day Year 5 ☐ Other (specify) 0 the 8 Tyes 2 No detached 9 Unknown signed by the σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has N autopsy performed page 1 ☐ Yes 2 No 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient မ 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 □Yes 2 □ No 24 hours after death. Funeral Director: A filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, -Year) -

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M. D. 76 32. Registrar s Signature

30. Name an add ss of person who completed cause of death (Item 23a) (Type, Print)

MEHTA.

29c. License number

D41410

ER DRIVE

29d. Date signed (Month, Pay, Year)

TOWSON, MARYLAND 21204

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) **Physician** 3:20AM 2009 Greene Hartwell /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSPITAL BALTIMO RE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Min. (Month, Pay, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 86 Jan. 16. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinan must be notified a 1 MYes 2 □ No Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important; if frem 27 is marked other that any Injury or other traumatic event; In a once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be iston Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Ave. Baltimore, InD 20a. Method of Disposition 1 Verial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Pervice Licensee 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 weeks duct Obstruction **Physician** /Medical Due to (or as a consequence of): Examiner care zertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (gras a consequence of) requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performe 1 □Yes 2 No certificate 1 ☐Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA ျ 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVR, ZILBERMINIT

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible per family amend item 20b per fb g895 9-1-09 vt Amend Items Are Legible per family State of Maryland Department of Health and Mental Hygiene G896 10/14/09 dk Certificate of Death Reg. No. 6 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26, 09 **Physician** 1:12 P M Harris August Lamarr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Baltimore 2002 Eagle Street 1st. Floor Birthplace (State or Foreign Country)
 D If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
06-24-49 5. Social Security Number Sex M ⊿ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 217-50-7351 60 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ms 23a or 28a-f show X 1 Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 2002 Eagle Street 1st. Floor 21223 Funeral 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, it is included. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: American δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade Self-employed Home Improvement Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christine Traynham Esther-----Harris Andrew Harris -Louis-----Harris ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2002 Eagle Street 1st. Floor Baltimore, MD 19a. Informant's Name/Relationship (Type. Print) Latrice Harris-Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 09-<del>01</del>-09 1 N Burial 2 □ Cremation 3 □ Removal from State Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early pine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate clause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a conseq Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Thereat Director: After this certificate has been signed by the attending physician relay filled in by the funeral director, page 2 should be detached for use as the buring. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖪 No 1 ☐Yes 2√No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Nes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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82. Registrar's Signature

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31. Date filed (Month, Day, Year)

AUG 28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 9 Amend Items 25,27,28a-f per me. 8894,08/27/09dhb Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** SOHN SON 13 2009 AMES Ugust /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Vantage House Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 11,1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days South Carolina Months 1 X M 2 □ F 579-14-5225 91 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 🛣 No Director Howard Columbia Maryland 1 illed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5400 Vantage Point Road G1 21044 Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ss 1 and 2 should be filed within 72 hours after deat for Health and Mental Hyglene. If Health 21 is marked other than "natural"; or items 3 other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Lawver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Barron Charles Johnson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2106 N. Ohio Street Arlington, Virginia 22205 Paul Johnson (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition mit. Pages 1
Department of He
Important: If iten
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 8-25-2009 Olney, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road Columbia, Maryland 21045 rt1. Enter the fisease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical RIPPRANTITUS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner certificate be executed physician and s the burial-trans APPROXED BY H Due to (or as a consequence of): CERTIFICATION Division or Vital Records, P.O. Box 68760, attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Linknown 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has le 2 autopsy performed page certificate 1∐ Yes 2 No antage or Attending Physician: director, 25. Was case referred to fiedical examiner?
1 A Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) Found 08/03/2009 funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation Iniurv Multiple falls 1 ☐ Yes 2X No **Unknown**<sup>M</sup> 2 X Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City of Town, 5tell) Vantage Point Rd. Columbia, MD 3 ☐ Suicide 4 Homicide Assisted Living Facility Found: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier bely MD

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENNETH CIEH, ND 300 ARMORY PL, SUITE 36 RALTIMORE ND 21201. 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item I per dr., 2894,08/28/09dhb
State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 23aPtI per me, g894,08/27/09dhb
Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | Reg. No. 2 | 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Kim Gi Hyun Day Year Month **Physician** O M 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and n Examiner resity of M. MREYICOL 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) Funeral 7. Age Days Hours Months 1 M 2 □ F 46 086-88-8428 1963 South Director Korea Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 Begonia Court 21234 South Korea Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: Completed by Korean 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental Mee Sun Kim Soon Ja Kim Pages 1 and 2 should 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Mrs. Mee Sun Kim/ spouse 12 Begonia Court Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition July 28, 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland re of Fineral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on eacy Immediate Cause (Final disease or condition resulting in death) (Probable Tracheo-Vascular **Physician** Fistula) /Medical Due to (or as a consequence of) Examiner Dependence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertensive Cardiovascular Disease APPROVED HE OC Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown ۵. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 2 00 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 1 24a. Was an has autopsy this certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 res 2 results No director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manne T Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 5 ☐ Pending investigation Division (Month, Day, Year) atural Injury 1 □Yes 2 □No r death. neral Director; A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cer who completed cause of death (Item 23a) (Type, Print) 0 J (Month, Day, Registrar's Signature State **AUG 28** Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Daniel Thomas Kendrick 24,2009 2:20A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Seasons at Northwest Balto. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F Yrs September 24.1935 Director 212-34-7076 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, to a medical event, to a medical event, to a medical event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Md. Balto. Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3 Beaver Oak Court 21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Tres 2 No If Yes, Give Year or Dates:1958-1964 1 Never Married 2 Married Maryland 21215-0036 1∐Yes 2**V**∏No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Receiving 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Unknown Alice (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr Rose Marie Kendrick Spouse 3 Beaver Oak Court Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-28-2009 Garrison Forest OwingsMills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician End-Stage COPI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending ohysician and Due to (or as a consequence of): the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital 1 ☐ Yes 2 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifie (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 8/24/09. MS Kajapahsem D D0057465 &X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S Rajafa File, M D 25 Main St. Suite 200, Reisterstown, MD. 2113 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/200

Baltimore.

P.O.

Division of Vital Records,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	ryland / Depa Cer	artment of He rtificate of D				A 10 114 A A
	_		Registrar  1. Decedent's Name (First, Middle, Last)		timodio or E		2. Date of Death	n - 0 9	3. Time of Death
ı	Physicia /Medic		· ·	zmerski			Angust	27 2009	3:45 PM
af it	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Death	n	
***			Baltimore Washington Med.			en Burnie			e Arundel
н	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/13/1	Year) Cou	nplace (State or Foreign untry) MD
10			Usual Residence of Decedent	02			03/13/1	, , , , , , , , , , , , , , , , , , , ,	
	yland how		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	a-fs	Director	MD Anne Arundel		G1e	en Burnie			1 □Yes 2 🙀 No
	or 28	)ire	10e. Street and Number		10f. Zip Code		10	og. Citizen of What Cou	untry?
	th wi		113 First Avenue, S			21061		U.S	.A.
	ems	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13.1	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Eventiner must be notified at once.	by F	1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ N If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	0 T242-	1 □Yes 2 ☑ No	Specify:		Specify:	White
21215-0036	tural stural	ed	15. Decedent's Education		dent's Usual Occupa			16b. Kind of Business/l	
15	in 72 n "ne	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	life.	kind of work done di DO NOT use retired)	uring most of work	ring		
212	d with giene ir tha	щó	12	+)	Techni	ician		U.S. Gov	vernment
פר	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	-		18. Mother's Nam	e (First, Middle, N	faiden Surname)	
Maryland	Menta	10	Frank Kazmerski			Cather	ine Bern	oski	
ar	2 sho and is ma		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Z	
≥,	and lealth m 27		Mrs. Mary Lou Kazmerski /		3 First Av				yland 21061
altimore,	jes1 tof⊢ Ifite orotl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place			20c. Location - City or 1	Iown, State
Ë	. Рас tmen tant: jury		4 ☐ Donation 5 ☐ Other (Specify)	1	ss Cemeter		1/2009	Brooklyn,	
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licensee	<u> </u>	2. Name and Addres				Burnie, MD
			23a. Part 1. Enter the disease, or complications that caused	,				on Service	Approximate
			at and a with a set full control to be a state of a second and a set of the	e. OVUVASC				,	Interval Between Onset and Death
	Physician /Medical			a consequence of):	ular r	CCCOSE			
-B	Examiner		. Due to (or as a	a consequence or,					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):					
	nd rans	Examiner	that initiated events C.						
, 0	oe exe		resulting in death) Last Due to (or as a	a consequence of):					
68760,	ficate be executed physician and s the burial-trans t	edical	d						
9 ×	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy					
Вох	eath certifi attending for use as	ian	in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	,		23d. Date of deli Month	Day Year
o.	at the de by the a tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	time of death 31					
σ.	res that signed b be deta		Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	quires an sig uld be	ed by					1 □ Ye	es 2 □ No 3 □ Pr	obabiy 4 Unknown
000	law requir las been s 2 should	olete					24a. Was ai	n 24b. Were au	topsy findings available
ž	: The Is cate ha	Completed					autops perform 1 □ Yes 2	y prior to death? ned? death? 2 □No 1 □ Yes	completion of cause of
ital	ician: The certificate ector, pag	BeC	25. Was case referred to medical			26. Place of Dea	th (Check only on		Z. IEI NO
>	nysician: nis certific director,	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatie	nt 2 ER/Outpatie	nt 3 □ DCA Othe	er: 4 🗆 Nursing H	ome 5 🗆 Reside	ence 6 Other (Spec	cify)
0 _	ding Ph h. After th funeral		27. Manney of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injul (Month, Day		f 28c. Injury Work	/ at ?	28d. Describe ho	w injury occurred	
sio	• Attendi er death. rector: A by the fu	cati	2 ☐ Accident investigation			/es 2 □ No			
Division of Vital Records,	after deatl	Certification:	4 Homicide determined building, etc	iry - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	iral Route Number,
_			29a. Certifier 1 Certifying Physician: To the best of						
VI	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	f examination and/or in ited.	nvestigation, in my op	pinion, death occu	rred at the time, d	ate and place, and due	to the cause(s)
1	To t To t	Σ	29b. Signature and title of certifier	ili Mo	29c. License	number	2 2	9d. Date signed (Monti	h, Day, Year)
			P. Medic C VVV			11001	7	ingust 2)	1 200/
			30. Name and address of person who completed cause of di	eath (Item 23a) Type,	Bring 301 M	ospital	Drive,	Ger Bu	7, 2009 Vnze MD,
	Sta Registr		31. Date filed (Month, Day, Year) 32. Segistra	ar's Signature	- 60				

DHMH 17 Rev 1/2001

Kazmerski, Stanley

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death AM 26 2009 Mary Liburd August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RANDALLSTOWN BAlto Genesis Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WEST INDIES 5. Social Security Number 7. Age (In yrs. last birthday) 580-07-8388 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BAIto. MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 U.S.A. Pulaski 2133 N 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BIK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOTEL HOUSE KEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELIZABETH HUGGINS SAMUEL Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2133 N. Pylaski ST. Balto, MD 21217 ORNA Huggins - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-28-09 CATONSVILLE, MD METro 21. Signature of Funeral Service License 22 Name and Address of Facility BARKET FUNETAL HOME 3512 Frederick Ave. Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherescherotic Cardiovascular disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760, a after death.

I Director: After this of in by the funeral d within 24 hours aft

To the Funeral Di

completely filled in

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

Be

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Examiner

Physician/Medical

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Completed

Be ( မ

Medical Certification:

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

1 Yes 2 No	4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	Width Day 16ai
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
		24a. Was an autopsy autopsy performed?  1
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (C	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work?	d. Describe how injury occurred

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

August 27, 2009

R144682 CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathy Dai # 200 25 Main Street Reisterstown

31. Date filed (Month, Day, Year) State Registrar

AUG 28 2009

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06638 State of Maryland / Department of Health and Mental Hygiene Robert McKinney 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 2121 hrs August 24, 2009 **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Good Samaritan Hospital **Baltimore City** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7, Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. Director 1 VIM 2 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 V No 'natural", or items 23a or 28a-f shov Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Never Married 2 Married Yes Specify: 4 Divorced Yes, Give Year Yes 2 1 No within 72 hours after Widowed ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. it: If item 27 is marked other than other traumatic event, the M. di al 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemeter) 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State ortant: Other Specify. -0 Donation 5 Signature of Funeral Service Licenses inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Pari I Enter the disease, or complications failure list only one cause on each line. Between Onset and /Medicai Death a NArcotic (morphine & methadone) intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical as noted 23a,27,28a-f,perME, g895 9/22/09 TT X UNPENDED physician the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 Yes 1 🗸 certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be of Vital Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Other Inpatient 2 V ER/Outpatient 3 DOA this 1 Yes 임 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28a. Date of Injury (Month, Day,Year 28b. Time of Injury Certification: Division Natural Yes 2 X No Pending Fd 8/24/09 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1615 Lyle Ct Parkville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide (Specify) home determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2009 O.C.M.E

\$

DHMH 17 Rev 1/2001

OCME 2006

State 31. Date filed Month Day Registrar

Laron Locke MD

111 Penn Street, Baltimore, MD 21201

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

-	Physician
	/Medical
7	Examiner

Division of Vital Records, P.O. Box 68760,

	For State Registrar				/ Depa	rtment of h	lealth an		tal Hygi	Are Legibl ene <sub>g. No.</sub> ?	0	2750
ysician /ledical	1. Decedent's Name (First		McGee					. 1	ate of Death	les de /	ear	3. Time of Death
aminer eral ctor	4a. Facility Name (If not in Baltimore W. 5. Social Security Number 217–38–8558  Usual Residence of Decection, State 10b. 6	ashington	n Medica	e (In yrs. la		4b. City, Town, o Glen Bu If Under 1 Year Months Days	rnie	Hrs. I a n	Date of Birth Month, Day, In 16,	4c. County of <b>ANNE</b> Year) 9 1941	Birthpl Count	RUNDE Cace (State or Fore
any injury or other traumatic event, the Madical Examinations that neithful at once.  To Be Completed by Funeral Director	MD Anne Arundel Harman  10e. Street and Number 10f. Zip Code  7514 Harmans Road 21077						4	g. Citizen of What				
cal Evarrence oust	3 ☐ Widowed 4 ☐ D	1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☐ No  If Yes, Give  Year or Dates:				Vas Decedent of H Yes, specify Cuba Yes 2 No		14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry				
event, the Madical B Be Completed	(Specify only Elementary/Secondary ( 12  17. Father's Name (First, I	y highest grade co (0-12)	mpleted) College (1-4or 5	+)	`life. [	kind of work done OO NOT use retired ISTRESS	d)			Own Busi	Laes	દ
r traumatic ev								City or Town, St	ate, Zip	Code)		
any injury or oth	20a. Method of Disposition  1 A Burial 2 Cren 4 Donation 5 C  21. Signature of Funeral \$	mation 3 ☐ Rem Other (Specify)		1	owrid;	sition (Name of natory or other place ge Mem Pa . Name and Addre	ark   A	Date ugust 2009 Single	28, Feton F	Coc. Location - Ci Elkridge Uneral & Glen Bus	, MI	emation
for use as the burial-transit and a land a l	23a. Part 1. Enter the dise shock, or heart failul Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	re. List only one o	Due to (or as  Due to (or as  Due to (or as  Due to (or as	tal	ence of):  Bra ence of):  Ca	0 -1	ediy	rdiac or res	piratory arre	st,	Į.	Approximate Interval Between Onset and Death House Year Year Lycaus
etached for use as the b Physician/Medica	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 □Yes 2 ⑤No 9 □ Unknown	iani	If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	] Ectopic pregnand ] Other <i>(specify)</i> _	су			23d. Date Monti		ery Day Year
should be detached leted by Physic	Part II. Other significant of	conditions contrib	outing to death b	ut not result	ting in the ur	nderlying cause giv	en in Part I.				ute to th	e cause of death
actor, page 2 should  Be Completed	25. Was case referred to examiner?	medical					26. Place of		24a. Was ar autopsy perform 1 Tes 2 neck only one	prined? de:	or to cor ath?	psy findings avalla npletion of cause 2  No
completely filled in by the funeral director, page 2 should be detached for use as the t.  Medical Certification: To Be Completed by Physician/Medical	1  Yes 2 No  27. Manner of Death 1  Natural 5 □ 2  Accident	Pending investigation	1 ∐ Inpatie 28a. Date of Inju (Month, Da	y, Year)	28b. Time of Injury	Wor	rv at	28d.	Describe ho	nce 6 Other w injury occurred reet and Number state)	l	
ompletely filled in		ertifying Physic ledical Examiner		f examinati					t the time, da	ate and place, an	d due to	the cause(s)
Com	29b. Signature and title of 30. Name and address of	m M	.D.	leath (Item	23a) (Type,	29c. Licens	1292			9d. Date signed (	Month,	Day, Year)
State	S. JASS 31. Date filed (Month, Day	1600 CRA V. Year) 2009	32 Aegisti	ar's Signate	TEG	10, Gle	en Bun	mie	MI	b , 21	0	5]

4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 228 Sophia Ave. Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-18-1940 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 😾 F 218-38-4630 69 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10b. County 10a, State 10c. City, Town or Location "natural", or items 23a or 28a-f show The Medical Examiner must be notified at MD Carroll Westminister 757 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 757 Stone Rd. 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔼 No Specify. Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Muchan once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Para-legal 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jesse Harvey Wagner Mildred Catherine Gesell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Larry K. Wagner-brother 228 Sophia Ave., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Kriders Cemetery 8-29-2009 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home PA 21. Signature of Funeral Service Licensee Thomas D. 7 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of learn line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence & Other (Specify) Brothers 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year)

Miller

1. Decedent's Name (First, Middle, Last)

Wagner

Jennie

Physician

/Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10c per in 8894 8-28-09 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

25

Day 2009 Year

Aug

3. Time of Death

1:30 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Residence

Day

2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Pay, Year)

1 ☐ Yes 2 No

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division

State

Registrar

Medical

1 Natural

3 ☐ Suicide

29a. Certifier

29b. Signature a

2 Accident

4 Homicide

5 ☐ Pending investigation

6 Could not be

tle of certifier

determined

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

ter Street Westmister, MD 21157

State of Maryland	Department of Health and	d Mental Hygiene

		For State Registrar	State of Maryland		ificate of			Reg. No.	000	9 2760
Physicia /Medic		Decedent's Name (First, Middle, Last)     Howard	L.		Marsha		2. Date of D Month	t 25	Year 200	
Examine Funeral		4a. Facility Name (If not institution, give s  Manor Care Nurs  5. Social Security Number  6. Sex	ing Home	last birthday)		VSON If Under 24 Hrs Hours Min.		irth Pay, Year)	9. Bir	th' imore thplace (State or Fore ountry)
Director		Usual Residence of Decedent	81	Yrs.			03 (	)4 28	3	MD
-f show	tor	10a. State 10b. County  MD Baltimo		y, Town or Loca Ran	<sub>idallst</sub>	own				10d. Inside City Lim 1 ☐ Yes 2 ☑
or 28a enofil	Director	10e. Street and Number		- Kui	10f. Zip Code			10g. Citizer	of What Co	ountry?
23a		3708 Crossleigh	Ct.			133			U.S	. A .
o'll	by Funeral	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Tyles 2 No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	1	Black, Whit	erican Indian, re, etc. Black
r than "natur Ine Medical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	16a. Deceder (Give kir life. DC	nt's Usual Occup nd of work done ONOT use retire	oation during most of word d)	rking		of Business	
other th		10th grade	na .	Lo	ngshor		(F)		al #	323
0 0	D Be	17. Father's Name (First, Middle, Last) Raymond Marshal	1			18. Mother's Nar Katie		e, Maiden Sui	rname)	
7 is marked o traumatic eve	၉	19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street	and Number or R		ber, City or To	wn, State,	Zip Code)
Item 27 i		Betty Marshall-	Wife							, Md 211
	1	20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ R		lace of Dispositi emetery, cremat			Date		_	Town, State
Important: If any Injury or once.	1	4 □ Donation 5 □ Other (Specify)  21. Sign ture   Funeral Service License		yland			31/09	Laur	eı,	Maryland
any l	1	> Sonald C	, Anon	430		sh Ave			Md	21215
	V	23a. Pa I.A. Enter the disease, or complied sock, or heart failure. List only on	ations that caused the death e cause on each line.	n. Do not enter	the mode of dyi	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
sician edical	1	Immediate Cause (Final ease or condition resulting in death)	Pancrea	itic o	Como	er				5 days
miner		Toolaing in death)	Due to (or as a consequ	uence of):						
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequ	uence of):						
ind transit	Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events  c								
		resulting in death) Last	Due to (or as a consequ	ience of):						
s the	edical	d								
attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗆 🛭	death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year	
S 5 1		Part II. Other significant conditions con	tributing to death but not resu	ulting in the unde	erlying cause giv	en in Part I.	23e. Did	tobacco use	contribute t	o the cause of death
deta	ed by						1 🗆	Yes 2X	1o 3□ F	robably 4 ☐ Unkn
p e q	3							0.00	4b. Were a	utopsy findings avail
ss been signe 2 should be d	ă						24a. Wa		prior to	completion of cause
ss been signe	Comple						aut	opsy formed?	prior to death? 1 ☐ Ye	completion of cause
ss been signe 2 should be d	Be Completed	25. Was case referred to medical examiner?	venital:		Oth	26. Place of De	aut per 1 □Yes ath <i>(Check only</i>	opsy formed? 2 No one)	prior to death? 1 ☐ Ye	s 2 No
ss been signe	To Be	examiner?	ospital: 1 □ Inpatient 2 □ I	ER/Outpatient		er: 4 Nursing I	auti per 1 □Yes ath <i>(Check only</i> Home 5 □ Re	opsy formed? 2 No one) sidence 6	prior to death? 1 □ Ye ]Other (Sp	s 2 No
ss been signe 2 should be d	To Be	examiner? 1 ☐ Yes 2 X No	ospital: 1 ☐ Inpatient 2 ☐ I 28a. Date of Injury (Month, Day, Year)		28c. Injui	er: 4 Nursing I	aut per 1 □Yes ath <i>(Check only</i>	opsy formed? 2 No one) sidence 6	prior to death? 1 □ Ye ]Other (Sp	s 2 No
2 should be d	To Be	examiner? 1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury	28b. Time of Injury	28c. Injui Wor M 1	er: 4 Nursing I y at k?	autiper 1	opsy formed? 2 XNo one) sidence 6 E	prior to death? 1 ☐ Ye ]Other (Spi	completion of cause
as been signe 2 should be d	edical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Phys	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hor	28b. Time of Injury  me, farm, street  wledge, death o	28c. Injunger Worn 1 M 1 t, factory, office	er: 4 😿 Nursing H ry at k? Yes 2 □ No me, date and plac	autreper 1 □ Yes ath (Check only Home 5 □ Res 28d. Describe 28f. Location City or To	ppsy ppsy ppsy ppsy ppsy ppsy ppsy ppsy	prior to death? 1 □ Ye  ]Other (Spiccurred	completion of cause s 2 No ecity)  fural Route Number, as stated.
2 should be d	To Be	examiner?  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  H  27. Manner of Death 1 X Natural 2   Accident 3   Suicide 4   Homicide  1 X Certifying Phys 2   Medical Examin	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hose building, etc. (Specify lician: To the best of my knower: On the basis of examinat and manner stated.	28b. Time of Injury me, farm, street // wledge, death of tion and/or investing.	28c. Injunt Wor M 1  t, factory, office stigation, in my of the stigation in my of the stigation.	er: 4 W Nursing H y at K? Yes 2 □ No me, date and plac ppinion, death occ	autresse ath (Check only Home 5 □ Reserved 28d. Describe 28f. Location City or Tourned at the time	one) sidence 6 c how injury of (Street and Nown, State) e cause(s) ar	prior to death?  1 Ye  Courred  Jumber or Fadd manner acce, and du	completion of cause is 2 No ecify)  tural Route Number, as stated, e to the cause(s)
he Funeral Director: After this certificate has been signe pletely filled in by the funeral director, page 2 should be d	Medical Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hose building, etc. (Specify lician: To the best of my knower: On the basis of examinat and manner stated.	28b. Time of Injury me, farm, street // wledge, death of tion and/or investing.	28c. Injunt Wor M 1  t, factory, office stigation, in my of the stigation in my of the stigation.	er: 4 W Nursing H y at K? Yes 2 □ No me, date and plac ppinion, death occ	autresse ath (Check only Home 5 □ Reserved 28d. Describe 28f. Location City or Tourned at the time	one) sidence 6 c how injury of (Street and Nown, State) e cause(s) ar	prior to death?  1 Ye  Courred  Jumber or Fadd manner acce, and du	completion of cause s 2 No ecify)  tural Route Number, as stated, e to the cause(s)
as been signe 2 should be d	Medical Certification: To Be	examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and add of person to continue the determined	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At hose building, etc. (Specify lician: To the best of my knower: On the basis of examinat and manner stated.	28b. Time of Injury me, farm, street // wledge, death of tion and/or investing.	28c. Injunt Wor M 1  t, factory, office stigation, in my of the stigation in my of the stigation.	er: 4 W Nursing H y at K? Yes 2 □ No me, date and plac ppinion, death occ	autresse ath (Check only Home 5 □ Reserved 28d. Describe 28f. Location City or Tourned at the time	one) sidence 6 c how injury of (Street and Nown, State) e cause(s) ar	prior to death?  1 Ye  Courred  Jumber or Fadd manner acce, and du	completion of cause s 2 No ecify)  tural Route Number, as stated. e to the cause(s)

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:45 A<sup>M</sup> 2009 AUGUST 22, WILLIAM FELDER MULLIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Abingdon 1217 Coyote Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Young)
Sep. 17, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Georgia **Funeral** Year Months Days Hours 1**X** M 2 □ F Sep. 1919 89 256-44-9967 **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Modical Examinations to notified at 1 ☐ Yes 2 No Director Maryland Montgomery Damascus 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20872 9200 Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Mullis Odie Estelle Parkerson မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau Pages 1 and 2 1217 Coyote Court, Abingdon, MD 21009 Carol Carr-Smith / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 8-31-09 Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, Abingdon, MD 21009 1317 Cokesbury Road, 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ale (cnier Vear Physician INS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 200 1 □Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Daughter 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Residence 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral bletely filled in bletely filled in by the funeral bletely filled in bletely filled death. 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tyle of certifier 29c. License number MI ss of person who ause of death (Item 23a) (Type, Prin 30. Name and 911 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 296,20°9 Physician/ CHESTER LEE TRUBUK RUBY, SR. 12:21AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death Examiner TOWSON GILCHRIST HOSPICE CENTERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. 9-6-1924 218-18-8414 MARYLAND 8 4 Yrs. Director Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director JOPPA Examiner must be notified MD HARFORD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 576 RENEE DRIVE APT. D 21085 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status 14. Race - American Indian Black, White, etc. o, þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) CHEMIST PROCTOR & GAMBLE Be Father's Name *(First,* CHESTER 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET
J. RUBY (PATTERSON) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3516 HONEYSUCKLE LANE CHESTER L RUBY, JR/SON BALTIMORE, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State PARKWOOD CEMETERY 8-28-09 PARKVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Folia A Service licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ tailure idney disease or condition resulting in death) wecks Medical Due to (or as a nsequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to for sels consequence of -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-t Physician/Medical Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an certificate has I autop performed, 2 No page death? bractu 1 🗌 Yes 2 🗆 No the Hospital or Attending Physician: I hin 24 hours after death. 25. Was case referred to medical examiner?

1. Yes 2 \( \square\) No æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) G. (Christ 욘 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury ☐ Natural 5 Pending 1 Yes 2 No UNKNOUN M fell in nusing home by Investigation Director: / August 14,2009 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Tumber or Rural Route Number, City or Town, State) determined Genesis Cramuell nursing home 8710 Enge Rd Parkvilling 2123 24 hours e Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Marian Grant

31. Date filed (Month, Day, Year)

AUG 28 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

N. Charles

32. Registrar's Signature

TOUSON,

St

R149194

29d. Date signed (Month, Day, Year,

August 26,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ROBERT LEE RINKER AUGUST 25, 7:22 P M 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2623 Thornberry Drive Edgewood Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 27 **Funeral** 9. Birthplace (State or Foreign Days **№** M 2□ F Months Hours Director 215-40-6245 68 Yrs Nov. Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Widden Eventree must be nothing at Directo 1 ☐ Yes 2 No Maryland Harford Edgewood 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2623 Thornberry Drive 21040 2 should be filed within 72 hours after death on and Mental Hygiene.

Is marked other than "natural", or Items 239 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Steel Worker Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Lee Preston Rinker Stella Myrle Murray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine N. Rinker / Wife 2623 Thornberry Drive, Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-29-09 Towson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final llanone Onset and Death **Physician** Syen. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Und the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami and I-tran. physician a s the burial-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 300 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 2 300 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Nother (Specify) Hospital: 1 Yes 2 No Certification: To funeral dir 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation filled in by the fi 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 038409 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Sharton

31. Date filed (Month, Day, Year)

MO

32. Registrar's Signature

DHMH 17 Rev 1/2001

Falls Rd

#415 ( JUN 114 MY 21093

1375)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06644 State of Maryland / Department of Health and Mental Hygiene Timothy Sanders Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 25, 2009 0012 hrs Timothy Michael Sanders **Medical Examiner** 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Garrett Grantsville 575 Jennings Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign Baltimore, Country) Maryland **Funeral** Months Days Hours 8/17/1963 213-90-4976 Director 1 X M 2 46 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County Yes 2 X No Grantsville Garrett Maryland 23a or 28a-f show notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21536 575 Jennings Road America 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XX Never Married 2 Married White 1 X Yes Specify: If Yes, Give Year or Dates: Yes 2 X No specify: Divorced Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ner than " Roofing Roofer 12 marked other t 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Mae Hutchinson Bernard William Sanders, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ٩ or other traumatic Street, Maryland 21154 1395 Macton Road Mrs. Teresa M. Smith/ sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place August 27 2 XX Cremation 3 Removal from State Evans Funeral Forest Hill. Maryland Important: injury or oth 2009 Other Specify. Donation 5 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. 21. Signature of Funeral Service Licenses Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21093 Marvland Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Death **Medical** Contact Shotgun Wound of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pug Physician/Medical tending physician a AMENDED UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Por 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 þ Completed 24b. Were autopsy findings available 24a. Was an s been s prior to completion of cause of autopsy death? performed' has page 2 s ✓ Yes 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medica Division of Vital Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 DOA Inpatient ER/Outpatient 3 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury 28h Time of Injury 27. Manner of Death Certification: Subject shot self Aug 24, 2009 2335 hrs 1 1 Yes 2 ✔ No Natural Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide or Town, State) 575 Jennings Road, Grantsville, MD Could not be determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only

2x1

Medical one)

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day Year) State Registra

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 25, 2009

and manner stated.

IW

27608

			1 - For State Registrar	State of Maryla	•	artment of rtificate of			al Hygie <sub>Reg.</sub>		
			1. Decedent's Name (First, Middle, Las	st)		<u> </u>			te of Death		3. Time of Death
	Physici /Medic		Leonard Smr					Day Year	12 10 m		
The second	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location			4c. County of Deatl	h
41			NMMC			Boulail	no pe			N/A	
	Funeral		Social Security Number     6. S		rs. last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Da Min. (M	te of Birth onth, Day, Ye	ar)   Co	hplace (State or Foreign untry)
	Director		212-04-3431	X <sup>M</sup> 2 <sup>D</sup> F   46	Yrs.			Maı	c. 20,	,1963 Ma	rýland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	√aryl f sho	ō	37/3								No Yes 2 No
	the 1	Director	Maryland N/A	D	altimo	10f. Zip Code			10a.	Citizen of What Co	untry?
	with sa or		4007 Mortimer A	Troniie		21215			"	SA	,.
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13. 1	Nas Decedent of	Hispanic Or	igin? (Specify Ye	es or No-	14. Race - Amer	rican Indian,
9	within 72 hours after death with the Maryland gjene. Pr than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at		1 ☐ Never Married 2 【X Married	Armed Forces? 1 XYes 2 No		f Yes, specify Cul	oan, Mexicai	n, Puerto Rican,	etc.)	Black, White	Black
03	ral", c	i by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2√⊡No	Specify:			Specify:	Diack
5-0	72 hc inatu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		dent's Usual Occu kind of work done		st of warking	16b	. Kind of Business/l	ndustry
2	within iene.  than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)				
2	a filed wall Hygier other the		11th grade		<u>  Flag</u>	ger (Ce	1			onstruct	cion
and	be filed ntal Hyg sd other event,	a	17. Father's Name (First, Middle, Last)	la Gara			1	er's Name <i>(First</i> omi Ro		den Surname)	
ž	should by nd Ments marked	은	Leonard W. Smit								
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic es once.		19a. Informant's Name/Relationship (T Shala Smith/ Si	• • • • • • • • • • • • • • • • • • • •	19b. Mailir	g Address <i>(Stree</i> Mortin	t and Numb 1er A	er or Rural Roul Venue	e Number, Ci Balti:	ty or Town, State, 2 more <b>,</b> Mar	cyland 215
	1 and Healt em 2		20a. Method of Disposition		. Place of Dispo			Date		. Location - City or	
altimore,	Pages nent of I		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crer.	natory or other pla n Cemet	ace)			-	, Maryland
틆	it. Partme	. 8	4 □ Donation 5 □ Other (Specify  21. Signature Fineral Service Ligen	/ ,     · ·					,		
Ва	permi Depa Impo any ir		21. Signature de diferal Service Elcen		22	. Ivallie and Addr	ess or raciii	<sup>y</sup> Chatm	an-Ha:	rris Fur	neralHome
			23a. Part. Enter the disease, or comp	lications that caused the de			-			ttimore,	, MD 21215 Approximate
		8 0	shock, or heart failure. List only of mediate Cause (Final	one cause on each line.	A 1	DESCRIPTION OF THE PERSON		cardiac or resp	natory arrest,		Interval Between Onset and Death
-	Physician Medical	М	disease or condition resulting in death)	a. Manchente		ocaecin	uma				9 nonths
-8.0	Examiner			Due to (or as a conse	equence of):						
	. 2	ē	Sequentially list conditions,								
	uted d ansit	Examiner	d any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć	exection and an ital-tra	Exa	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	fficate be executed graphysician and sthe burial-transit	dical		d.							
9	tifica ig phr as th	ledi									(300)
P.O. Box	The law requires that the death certifinate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnan	01/			23d. Date of deli	ivery
B	deat ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of		Other (specify)				Month	Day Year
<u>Ч</u>	that the de ned by the a detached f	hys	9 🗆 Unknown	9 ☐ Unknown							
Ś	res that	by 8	Part II. Other significant conditions co	ontributing to death but not re	esulting in the ur	nderlying cause gi	ven in Part I	i. 23	Be. Did tobaco	co use contribute to	the cause of death?
ord	w requir been si should b	ed							1 🗌 Yes	2 No 3 Pr	obably 4 🗌 Unknown
Ö	e law r has be	Completed						24	ta. Was an	24b. Were au	topsy findings available completion of cause of
<u> </u>	ysician: The I iis certificate ha director, page	mo.							autopsy performed □Yes 2	? death?	2 □ No
<u>ita</u>	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place	of Death (Che			
<u></u>	hysic his co		1 Yes 2 No	Hospital: 12 Inpatient 2	☐ ER/Outpatier	t 3 □ DOA Ot	her: 4 □ Nı	ursing Home 5	Residence	e 6 □Other (Spec	cify)
u u	ng P	ü	27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju Wo	ıry at rk?	28d. D	escribe how in	njury occurred	
<u>sio</u>	death, ctor; / y the fu	cati	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2	No			
Division of Vital Records,	or Attending Phys after death. Director: After this in by the funeral di	Certification: To	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre c <i>ify)</i>	eet, factory, office			cation <i>(Str</i> ee) ty o <i>r Town, Si</i>	t and Number or Ru tate)	ıral Route Number,
	urs a		200 Contilion 450 Octobrilla In 191								
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director;	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, death nation and/or in	occurred at the trest estigation, in my	time, date ai opinion, dea	nd place, and du ath occurred at t	ie to the caus he time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	ithin o the	Mec	29b. Signature and title of certifier	and marrier stated.		29c. Licen	se number		29d.	Date signed (Month	n. Dav. Year)
	F 3 F 8		· Man	11000	MAD			CALOR			. ,
			30. Name and address of person who c	ompleted cause of chath /lt.	em 23a) (Time		CF OTI	5 M1963	XQ .	8/23/09	
			MORAN LAWIN	77	5 (0500	ne st	BAOK	hope 1	1Do	126.1	
	Stat	te	31. Date filed (Month, Day, Year)	ompleted cause of death (It	nature &		v.ce	1100	VIV	1401	
	Registra	ar	AUG 28 2009	Dense A	· Mark	_					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11: IOP M BARBARA SMITH AUGUST 23 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/ABALTIMORE JOHNS HOPKENS BANGEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, Year) **Funeral** Days Hours 1 □ M 2 □ F 217-40-1315 67 1942 Maryland Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the World Standard and 1 √ Yes 2 □ No Director N/ABaltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21213 2403 E. Preston Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ∐Yes 2√x No Specify: þ 3€ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker <u>12th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Smith John Thaxon ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 sment of Health an lant: If item 27 is jury or other trau 6124 Fortview Way Baltimore, Maryland 21224 Yolanda Barlow/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition Trinity Cemetery of other place) 9/1/09 Dundalk, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Fineral Service Lice See oall 5240 Reisterstown Rd Baltimore, MD 21215 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Immediate Cause (Final BOWEL **Physician** PERFORMITION 4 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 8 MONTHS LUNG CANCER Sequentially list conditions, Examiner Dise to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗖 No ĺ 4 ☐ Pregnant at time of death 5 Other (specify) the detached 9 I Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has perform 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST Z3, Z009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BAUTLYORE, MD ZIZZY MARC LAROCHELLE  $\mathcal{G}\mathcal{D}$ 31. Date filed (Month, Day, Year) Registrar's Signati State AUG 28 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:55 A M John R. Simpson 27, August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Heritage Nursing Center Dundalk Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours Min. 212 20 0307 84 Director Nov.21,1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event. The Medical Evant for that by nother all 1 ☐ Yes 2 X No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Frankewitz Rd. 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 21X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Common Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be Lawrence Stanley Simpson Helen Avery ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar of Health of Item 27 is Louise I. Simpson (Wife) 912 Frankewitz Rd. Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ≃ ৳ 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Parkwood Cemetery 8/29/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** egionn AIR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner EMEN TIP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is into a second can be caused to the cause of t Examiner Due to (or as a consequence of) or Attending Physician. The law requires that the death certificate be executed MALNUT use as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) the ☐Yes 2☐No 9 Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an page 2 After this certificate 2 2 No 1 □ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | 1 | No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manne: Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: ad in by the Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year). State Registrar

			For State Registr <i>a</i> r	State of Maryla		artment of F <i>rtificate of I</i>			giene Reg. No.	2009	27611
	Dhusisi		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		PAUL THEODOR	2E		ST	THEL	AUGUST	22	2009	12:15AM
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death			County of Deat	h
-			CARROLL HOSPITAL CEN		s. last birthday)	WEST MINS	STEP- I If Under 24 Hrs.	8. Date of Bir	h	RROLL	hplace (State or Foreign
	Funeral Director		5. Social Security Number 6. S 217 24 2584		30 Yrs.	Months Days	Hours Min.	3/30/	y, Year) 1 9 2 9	PE	NNSYLVANIA
	_		Usual Residence of Decedent					3/30/			
	ryland how	_	10a. State 10b. County		ity, Town or Lo		D				10d. Inside City Limits
	e Ma 3a-f s	cto	MD BALTI	MORE	MIDL	LE RIVE	K				1 □Yes 2 🔀 No
	or 2	Director	10e. Street and Number			10f. Zip Code			_	en of What Co	untry?
	s 23a	eral	44 HEBRON AVE	Lao Was Danadant Francis I	10 10	21220	liana ala Origina /Ca	acifu Va a or No		SA 4. Race - Ame	ringo Indian
	ter de item	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ever in the Armed Forces? 1 ☑ Yes 2 ☐ No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	`   '	Black, White	e, etc.
036	urs af	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates: KOR	EA	1 ☐Yes 2X No	Specify:			Specify: WI	HITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, I're Wedfea Evaminer must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	edent's Usual Occup	ation	dna	16b. Kin	d of Business/	Industry
7	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	d)	<i></i>	COO	TAT CI	CUDIMY
2	led w Hygier her th		10	0	C1	SERK	18. Mother's Nam	e /First Middle			ECURITY
Maryland	l be fi intal H ed ot	Be	17. Father's Name (First, Middle, Last PAUL T. STIHE				LUC		LEK	ourname)	
Ë	hould nd Me mark matic	오	19a. Informant's Name/Relationship		19b Maili	ing Address (Street				Town, State, 2	Zip Code)
<u>≅</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I's Marical Examiner must be notified at once.		CHRISTIAN P. S	**	1	GAMING					
Baltimore,	s 1 a of He item othe		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other plac	(e)	Date	20c. Loc	cation - City or	Town, State
E	Page nent on: If int: If		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia		OLY RE	EDEEMER	CEM 8/2			IMORE	
a	rmit. spartr porta iy inju		21. Signature of Funeral Service Lice	nsee							NERAL HOME
<u> </u>	9 4 F F 9		100		1	211 CHE	SACO AV	E BALT	IMOR	E, MD	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not en	iter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS							24 HOURS
-	/Medical Examiner		resulting in death)	Due to (or as a conse							/ 1. 1001
		e	Sequentially list conditions,	b. GANGRE  Due to (or as a conse							6 MONTHS
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. The sequence Cause (Disease or injury that initiated events	PERIPHE		ASCULAR	DISEASE				5 YEARS
oʻ	an an rial-tr		resulting in death) Last	Due to (or as a conse			1000				
68760,	icate be executed physician and the burial-transit	edical		d							
_	ertifica ling pl	Med	IF FEMALE:								
Box	leath certif attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnanc	y		2	3d. Date of del Month	ivery Day Year
<u>P</u> .0	at the de by the a tached f	Physician/M	1 □Yes 2 □ No 9 □ Unknown	4 □ Pregnant at time of 9 □ Unknown	death 5	Other (specify) _					
σ.	res that t signed by be detac		Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
rds	quires n sigr ald be	d by						1 🗆 '	Yes 2□	No 3□ Pr	obably 4 Unknown
000	aw requir is been si 2 should I	Completed						24a. Was		24b. Were au	topsy findings available
æ	Physician: The law r this certificate has ral director, page 2 a	шо						autoj perfo 1 □Yes	rmed?	death?	completion of cause of 2 □No
<u>ita</u>	sian: ertifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
× ×	Physic rthis or ral dire		1 ☐ Yes 2 ☑ No	L	☐ ER/Outpatie		4 LI Nursing H	ome 5 ☐ Resi			cify)
n c	ding P h. After funera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe	how injury	occurred	
Sic	ttend death stor: / the f	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 29a Place of Injury - At	home farm et		Yes 2 □ No	28f Location /	Street and	Number or Br	ural Route Number,
Division of Vital Records,	I or Attend after death Director: d	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	cify)	ioot, tactory, omco	•	City or To		744111001 07 711	arar riouse rvanicos,
_	spital of nours a neral E			nysician: To the best of my k							
1	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	nation and/or i	nvestigation, in my	opinion, death occu	irred at the time,	date and	place, and due	e to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier			29c. Licens			29d. Date	e signed (Mont	h, Day, Year)
			Elizabeth alice Jul	tiths, Medical Doc	her	D63	950	(	Rignot	- 22 20	009
			30. Name and address of person who	·							212.21
47	-01		31. Date filed (Month. Dav. Year)	32. Registrar's Sign	ROOM 186	1650 DELES	ins street	BALTIMO	EE, MI	aryland	21231
	Sta Registr	te ar	EUZAGETH GIFHATHS, CANCE 31. Date filed (Month, Day, Year) AUU 28 20	15 /	A So.	ra Kad					
			2 2 0 E0	renous	10. All 10	74					

			For State Registrar	State o	f Marylan		artment c rtificate d			and M	lental Hy	gien Reg. N	00	0.9	27	612
	Physici	an	1. Decedent's Name (First, Mid						el .		2. Date of D Month		ay	Year	3. Time of	
	/Medic		Charles How		<u> </u>						August			4 D 4h	4:05	РМ
	Examin	er	4a. Facility Name (If not institut		nber)		4b. City, Tow			f Death			c. County o altim			
	Funeral		Stella Maris 5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		f Under 2		8. Date of Bi (Month, D			9. Birthp	lace (State	or Foreign
	Director		213-38-5719	1 <b>X</b> M 2□F	69	Yrs.	Months Da	ays	Hours	Min.	Feb. 10	ay, rear <b>) , 19</b>	40	Mar	yland	
	pu)		Usual Residence of Decedent  10a. State 10b. Coun	tv	10c City	, Town or Lo	cation							1	0d. Inside C	city Limits
	Aaryla f sho	5		Harford	100.00,	Stre										2 <b>∑</b> No
	the A	Funeral Director	10e. Street and Number				10f. Zip Co	de				10g. C	Citizen of W	hat Cour	itry?	
	3a or	a Di	4016 Old Roo	cks Road			2	1154	1				USA			
	ems S	ner	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	S. 13.	Was Decedent If Yes, specify	of Hisp Cuban.	anic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	0-		- Americ	an Indian,	
р.ш. 036	or ite	by Fu	1 Never Married 2 M	arried 1 <b>X</b> Yes If Yes, Gi	2 □ No ve		1 ∐ Yes 2√∑		Specify:	,	. ,		Specify:		hite	
0	hours tural	ed b	3 ☐ Widowed 4X Divorce		ates:	16a Dece	dent's Usual O	ccupati	on			16b.	Kind of Bus	siness/In	dustrv	
4:05 p.m 1215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene was a sa or 28a-f show other than "natural", or items 23a or 28a-f show ent, the Madical Examitrat must be traffilled at	Completed	(Specify only high	ent's Education hest grade completed) College (1	Aor 5.1)	(Give life.	kind of work d DO NOT use re	one dur etired)	ring most	of worki	ng	1			-	
4: 212	d with giene	No.	8	, Conege (1	-401 5+)	Manu	ıfactur	er				Am	erica	n Cv	anamid	<u>f</u>
pu pu	should be filed within 72 hours after death with the Marylar nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 21a or 28a-f show marice event, the Madical Exprintment to realthal at	Be (	17. Father's Name (First, Middl					1			(First, Middle	e, Maide	n Surname	9)		
2009 'ylanc	should I and Men marke	၉		Stevens		T				adys					2 1 1	
AUGUST 26, 2009 altimore, Maryland	12sthaithai		19a. Informant's Name/Relation Charles Stever				ng Address <i>(St</i> I <b>orth</b> Hi									1
. 26 re, N	регтіі. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra once.	1	20a. Method of Disposition		20b. P				_		Date		Location - (			
AUGUST Saltimor	ermit. Pages epartment of nportant: If it ny injury or o nce.		1 ☐ Burial 2 😾 Cremation 4 ☐ Donation 5 ☐ Other	n 3 🗆 Removal from	State Eva	ns Fun Compti	sition (Name of matory or other leral Cl on Ser.B	nape hape	el A	lug.2	29,2009	F	orest	Hil	l,Mar	yland
UG alti	permit. Departmine Importal any inju		21. Signature of Funeral Service		au	22	2. Name and A	ddress	of Facility	у	3 1	! !ewp	ort D	rive	arylaf	21050
A W	B II G	5 8	Kindrae!	LMita	ds	a	ans Fu nd Cre	mati	on S	erv:	ices	'ore	st Hi	TT,M	arylaf	id
- 8		2 1	23a. Part 1. Enter the disease, shock, or heart failure. L	or complications that of ist only one cause on e	aused the death ach line.	n. Do not en	ter the mode of	f dying,	such as	cardiac	or respiratory	arrest,			Approxima Interval Be Onset and	te tween Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. COMMO	N BILE	DUCT (	CANCER								Onoot and	
	/Medical Examiner		resulting in deathy	Due to	or as a consequ	uence of):										
	128	-e	Sequentially list conditions, if any, leading to immediate	b	(or as a consequ	uence of):								-		
1130	siclan and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	G.												
0,	e exectan an an arrial-tr		resulting in death) Last		(or as a consequ	uence of):										
8760	ate the	lical		d												
89 ×	sertifica ding ph	/Mec	IF FEMALE:	220 Hype out	tcome of pregna	inev/										
Box	leath certific attending p for use as i	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2□Fetal nant at time of d	Ideath 3[	☐ Ectopic preg ☐ Other (speci						23d. Date Mor		ery Day	Year
S	requires that the death been signed by the atter hould be detached for u	Physician/Med	1 □Yes 2 □ No 9 □ Unknown	9 ☐ Unkr				.,,,								
STEVENS ords, P.(	uires that signed b d be deta	by Pi	Part II. Other significant cond	litions contributing to de	eath but not resu	ulting in the u	nderlying caus	e given	in Part I.		23e. Did	tobacco	o use contri	ibute to t	he cause of	death?
TE	w require s been sig should b										1	Yes	2 □ No	3□ Pro	oably 4X	Unknown
O	law re as be 2 sho	plet									24a. Wa	s an opsy	24b. V	Vere auto	psy findings	available cause of
CHARLES STEVE I Vital Records,	sician: The law certificate has birector, page 2 sl	Completed									per 1 □ Yes	formed?	'   d	eath?	2 🗆 No	
HAR Vita	certific ector,	Be	25. Was case referred to medie examiner?	cal Hospital:							h (Check only					
٥ ص (	Phy this	-T	1 ☐ Yes 2 ▼ No 27. Manner of Death	28a. Date	Inpatient 2  of Injury	ER/Outpatie 28b. Time o		Other:	4 ⊔ Nu		me 5 Re 28d. Describe				(y) HOSP	CE
	ng fte	tion	1 Natural 5 ☐ Pend	/A 4 a m	th, Day, Year)	Injury	M 250.	Injury a Work? 1 ☐ Ye	s 2 🔲		Zou. Describe	; now m	july occurre	, ,		
Division	Atten r deal	ifica	3 ☐ Suicide 6 ☐ Cou	ld not be	of Injury - At ho ing, etc. (Specif	me, farm, st	l reet, factory, of	fice		-	28f. Location			er or Run	al Route Nui	mber,
Ö	s afte	Certification:	4 ☐ Homicide dete	Bulla	ing, etc. (Specif	у)				ļ	City or T	own, Sta	are)			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral		(Check only 2 Medic	ying Physician: To the	best of my kno asis of examina	wledge, deat	th occurred at a	the time	e, date ar	nd place, ath occur	and due to the	e cause e, date a	e(s) and ma and place, a	nner as	stated. o the cause(	(s)
	the F the F mplet	Medical	one) 29b. Signature and title of certi		ner stated.		290 1	icense r	number			20d F	Nate signed	(Month	Day, Year)	
	<b>5</b> ≥ <b>6</b> 8	1	250. Signature and title of certi	)WI_			7		372	5		X	127	100	]	
	Ex,		30. Name and address of person	on who completed caus	se of death (Item	n 23a) (Type.	Print)	-(	7/2	- 1		7	1		1	
			TARTO WATIMOOD	MD 3300	DULANEY		,	TI	MONI	UM,	MD 210	93				
48	Sta		31. Date filed (Month, Day, Yea	ar) 32.	egistrar's Signa	ture										
	Registi	ar	NUG Z	o ZUUS ZA	neva a	g. A	arke									

Registrar DHMH 17 Rev 1/2001 Be Completed by Funeral

2

Examiner

Be Completed by Physician/Medical

Medical Certification: To

TARIQ MAHMOOD, MD

AUG 28 2009

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ith IM dical Exeminations to profiled at any injury or other traumatic event, Ith IM dical Exeminations to approach Baltimore, Maryland 21215-0036 AUGUST 26, 2009

a.m.

3:15

**Physician** /Medical Examiner

MARY SCHAFER

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

				nk. Ensure Al			
For State Registrar	otate of Mary	•	artment o rtificate o	of Health and M of Death	Reg	g. No. 2009	27613
1. Decedent's Name (First, Middle, Last)	LIAN	SCHA	FER		2. Date of Death Month AUGUST	Day Year 26,2009	3. Time of Death 3:15A M
4a. Facility Name (If not institution, give st STELLA MARIS H		ENTER		vn, or Location of Death IMONIUM		4c. County of Deat	TIMORE
217-22-0331	7. Age (In	yrs. last birthday) 82 Yrs.	Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, 7 – 8 – 19	Year) 9. Bir 27 MA	thplace (State or Foreign ountry) RYLAND
Usual Residence of Decedent  10a. State 10b. County  MD H2	ARFORD 10	c. City, Town or Lo	ocation	BALDWIN			10d. Inside City Limits 1 □Yes 2 XNo
10e. Street and Number 2601 BALDWIN MI	LL ROAD		10f. Zip Co	21013	10	og. Citizen of What Co	
11. Marital Status  1 Never Married 2 Married  3 Woldowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 \( \subseteq Yes \) 2 \( \subseteq No \) If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent If Yes, specify 1 □Yes 2X	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto ] No <i>Specify:</i>	o Rican, etc.)	14. Race - Ame Black, Whit Specify: WH	te, etc.
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	DO NOT use re	tone during most of work		16b. Kind of Business. ENTREPR	
17. Father's Name (First, Middle, Last) HENRY NICH	OLAS	TELLJOI			ne (First, Middle, M.		(BUSSE)
19a. Informant's Name/Relationship (Type CHRISTINE DALTO)	oe. Print) N/DAUGHTE	ER 261	ing Address (S. 1 BALD	itreet and Number or Ru	ral Route Number, ROAD B	City or Town, State,	MD 21013
20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	ernoval from State	ST. JOI	ematory or othe HN 'S C	HURCH 8-2	9-2009	•	r Town, State  MARYLAND  INERAL HOMI  1D 21237
23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	Sepsionsequence of):	S	of dying, such as cardiac		est,	Approximate Interval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	☐ Ectopic preg			23d. Date of do Month	elivery Day Year
Part II. Other significant conditions con	ntributing to death but n	ot resulting in the	underlying caus	se given in Part I.			to the cause of death?  Probably 4X Unknown
25 Was soon of the same of the				00 5		prior to med? death? 2 No 1 □ Ye	autopsy findings available o completion of cause of ? es 2 □No
25. Was case referred to medical		2 ☐ ER/Outpati		Other: 4 Nursing H		ence 6X Other (Sp	
examiner? 1 ☐ Yes 2¶ No	lospital: 1 ☐ Inpatient	28b. Time		. Injury at	28d. Describe ho	w injury occurred	pecify) HOSPICE
examiner?  1 Yes 2 No  27. Manual 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Yo	28b. Time Injury	М	o. Injury at Work? 1 □Yes 2 □ No office	28f. Location (St.	treet and Number or I	
examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 2  Accident 3  Suicide 4  Homicide  1 Could not be determined	28a. Date of Injury (Month, Day, You building, etc. (	28b. Time (ear)  - At home, farm, s (Specify)	M street, factory, o	Work? 1 □ Yes 2 □ No  office	28f. Location (St. City or Town	treet and Number or I n, State) cause(s) and manner	Rural Route Number, as stated.
examiner?  1  Yes 2 No  27. Manner of Death  1 Natural  2  Accident  3  Suicide  4  Homicide  1 Could not be determined	28a. Date of Injury (Month, Day, You building, etc. (	28b. Time Injury  - At home, farm, s (Specify)  my knowledge, dexamination and/or	M street, factory, o ath occurred at investigation, ir	Work? 1 □Yes 2 □No office	28f. Location (St. City or Town e, and due to the curred at the time, d.	treet and Number or In, State) cause(s) and manner date and place, and drawled and place, and drawled and place and	Rural Route Number, as stated. ue to the cause(s)

DHMH 17 Rev 1/2001

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32 Registrar's Signature

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:40P Edwin Joseph Tress, Sr. 24, 2009 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 1 X M 2 □ F 90 215-03-9083 June 9, 1919 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ∏Yes 2 X No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 United States 2436 Woodcroft Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: ğ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier Postal Service 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret J. Blessing Walter J. Tress, Jr. Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2436 Woodcroft Road Baltimore MD 21234 Iris Tress - Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 8/28/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services Stacre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS SYNDROME disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner BILATERAL PNEUMONIA Se uentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and-trar Due to (or as a consequence of): O. Box 68760, the attending physician hed for use as the burial death certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 I Unknown ٣. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>გ</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ONCESTIVE HEAR Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ After thi 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dill completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D17695

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HELOU. 7601 OSLER DRIVE TOWSON, ABDALLAH J. M. D. MARYLAND 21204

State Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician 7310 AH M AUGUST 300% /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/ABaltimore Tercy Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 M 2□F Months 212-34-1775 71 Director Sept.7,1937Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Maryland N/A XXYes 2 □ No Director Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f, Zip Code 1327 N. Calhoun Street 21217 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2√2 No Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced th and Mental Hygiene.
?? is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Laborer Water and Waste 11th grade
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Chambers Annie E. Turner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Judy Turner/ Wife 1327 N. Calhoun Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State ′29/09 King Memorial Park Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Serviced 5240 Reisterstown Road Baltimore, MD 21215 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure due to COPD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 217No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 V Natural within 24 hours after death.

To the Funeral Director A completely filled it by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

AUG 2*8 2*009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number / NIT

1245869367

29d. Date signed (Month, Day, Year)

AUGUST, 71, 2009

	<b>1–</b> For State of Maryland / [ Registrar	Department of Health and I Certificate of Death	Mental Hygiene Reg. No. 2009 276
Dhysisian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of De
Physician /Medical	William E. Toomey		August 25, 2009 5:50
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
Europol	1013 Hobbs Drive  5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Silver Spring  thday) If Under 1 Year If Under 24 Hrs.	Montgomery   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or I
Funeral Director	015 00 0000	Yrs. Months Days Hours Min.	(Month, Day, Year) Country) 5/20/1931 MA
D .	Usual Residence of Decedent		10d. Inside City
shov	10a. State   10b. County   10c. City, Town   MD   Montgomery   Silve	r Spring	1 ☐ Yes 2
the wind in 2 hours after death with the waryand that Hyllegen than "natural", or items 23a or 28a-f show event, the Medical Experiment must be notified at Be Completed by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner Trust be notified at once.  To Be Completed by Funeral Director	1013 Hobbs Drive	20904	USA
ems uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
lr, or il	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Divorc	1 ☐ Yes 2 ☐ No Specify:	Specify: White
ted ted	15. Decedent's Education 16a	. Decedent's Usual Occupation	16b. Kind of Business/Industry
nt, the Medical E	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of work life, DO NOT use retired)	Federal
∯ S		Attorney	Government
even Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Surname)
marke matic	John Denis Toomey  19a. Informant's Name/Relationship (Type. Print)  19b	Alma Dr	ury eral Route Number, City or Town, State, Zip Code)
27 is		13 Hobbs Dr. Silver	
othe	20a. Method of Disposition 20b. Place o	f Disposition (Name of ry, crematory or other place)	Date 20c. Location - City or Town, State
17 o	1 Li Buriai 2000 remation 3 Li Removal from State	į	/2009 Beltsville, MD
y inju	21. Signature of uneral Service Licensee M0153	9 22. Name and Address of Facility Ra	pp Funeral & Cremation Svc
E # 9	Mrs CC	933 Gist Ave. Silv	er Spring, MD 20910
100	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Betwee Onset and De
cian	Immediate Cause (Final disease or condition resulting in death)  Arrhythmia		Glisot and Bo
ical ner	Due to (or as a consequence	of):	
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence	of):	
Examiner	cause. Enter Underlying Cause (Disease of miny that initiated events  c.		
	resulting in death) Last Due to (or as a consequence	of):	
dical	d		
	IF FEMALE: 23c. If yes, outcome of pregnancy		
Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Ye
hysic	1  Yes 2 No 4 Pregnant at time of death 9 Unknown	3 - Other (apostry)	
P P	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of dea
should b	_Dysphagia		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Ur
ν <b>Q</b>			24a. Was an autopsy findings av prior to completion of cau
Som Com			performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Be (	25. Was case referred to medical examiner?		ath (Check only one)
1 di	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Ot	·	ome 5 Aesidence 6 Other (Specify)
tion:	1√ Natural 5 □ Pending (Month, Day, Year)	Time of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how injury occurred
led in by the runeral dir Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At home, fa		28f. Location (Street and Number or Rural Route Number
erti	4 ☐ Homicide aetermined building, etc. (Specify)		City or Town, State)
<b>□</b>			e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)
completely fil	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
8	295. Signature and the of certainer (100 cells)	D42518	8/26/2009
	30. Name and address of person who completed cause of death (Item 23a)		3, 23, 233
	Gul Chablani, MD; 1119 Rockville		le. MD 20852
State	31. Date filed (Month, Day, Year) 32. Registrar Signature	Red Steel 401 ROCKVII	
egistrar	AUG 28 2000 Choway B. Aga		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** M 21,2009 2:30P August Ricky Gene Valentine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** 8614 Manorfield Road Nottingham If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Director 51 May 14,1958 Maryland 212-76-3711 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland show 10a State 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Maryla lith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It o Mexical Extrainer must be notified at 1 □ Yes 2 No Director Md. Balto. Nottingham 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 8614 Manorfield Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dependent Disabled 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Bell Robert Valentine, Jr. Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4906 NW 4th Terrace Pompano Beach, Florida 33064 Health a Robert Valentine, Jr. Father permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8-25-2009 Bayview Balto, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home re of Funeral Service Licensee 9705 Belair Rd. Nottingham, Md. 21236 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Minutes /Medical Due to (or as a consequence of) Examiner 6 Marth if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) P.0. signed by the a 9 🔲 Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performa Aico Miconstance 2 certificate 2 1 ☐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Tes 2 XX Hospital: 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 1 🔲 Inpatient Certification: To this 27. Manner of Dath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 XINatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of person who completed 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24, <u>2009</u> 6:59 PM Vishnyakova Valentina August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 □ M 2 🗓 F Days Hours March 1 Country) 215-45-7135 Belarus Director 62 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Owings Mills 1 Yes 2 X No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21117 Belarus Jenner Court ıral", or items 2 I Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. . 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene.
s marked other than "r
umatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker it. Page 1 and 2 should be filed w rtment of Health and Mental Hygin rtant: If item 27 is marked other njury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zinaida Lebedeva Karp Ivanov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juliana Vishnyakov Jenner Court, Owings Mills, Maryland21117 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Oly Trinity Russian
Orthodox Cemetery 8-29-09Elkridge, Maryland 21. Signatury of Fun 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 6009 Harford Road, Baltimore, Maryland 21214 CAMBY ock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death diate Cause (Final Breast Cara Physician/ etastatic ase or condition Uevs Medical sulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Records, P.O. Box 68760 e esn . IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death led by the a 9 Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform death? 1 Yes 2 No 2 No this certificate 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital 2 X No Other: 4 Nursing Home 5 Residence 1 Tyes 6 Other (Specify) |₽ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Cate of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer work?
1 Yes 2 No injury 1. Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier K149194 Angust 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Marian Grant

31. Date filed (Month, Day, Year)

N.

701

84

Towson,

21204

MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Louanna L. White nanst 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rm 19nn-l Baltimore Washington Medical Center ni 8. Date of Birth (Month, Day, Year) May 18,1923 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 1 M 2 XF Months Days Hours Min. 86 May North Dakota 501-16-0393 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Severna Park filed within 72 hours after death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 641 Hawick Drive "natural", or items 23a 21146 Funeral S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White by 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ite INs Flementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Lunseth 2 Sophia Bentley 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Barbara W. Simpson/ 641 Hawick Drive Severna Park, MD 21146 Date 31, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2009 Maryland Vets. Cem. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services PA, 1 2nd Ave. SW Glen Burnie, MD 21061 NO1357 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical Physician: The law requires that the death certificate attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy page After this certificate funeral director, pag 1 □Yes 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 hpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 2 Accident (Month, Day, Year) 5 Pending 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD g895 9/3/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Grant B. Williams, II 2. Date of Death 4.18 Miams **Physician** 2007 25 mran b /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days **Funeral** 1 <del>X</del> M 2 □ F MARYLAND 224-19-1590 45 17. 1964 **Director** July Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State 28a-f show must be notified at 1y Yes 2 □ No Director Baltimore N/AMaryland 10g. Citizen of What Country? 10f Zin-Code USA 21213 2001 Ellsworth Street Funeral 14. Race - American Indian items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Black, White, etc the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 12th grade
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) event, 1 æ Ith and Mental F 27 is marked of traumatic ever Nancy Joyce Coles Grant B. Williams, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Grant B. Williams, Jr. / Father 4107 Hampstead Village Dr. Durham, NC 2770 of Health aitem 27 i other 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 8/28/09Baltimore, Maryland و <del>ت</del> ب Department of Important: If any injury or once. 22. Name and Address of Facilit Chatman-Harris Funeral Home 21. Signature of oneral Service Line 456 5240 Reisterstown Rd Baltimore, MD 21215 Sea. Part 1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death diate Cause (Final arrest **Physician** arauge disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pivabor Sequentially list conditions, if any, loading to in reclass cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Phenmon Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 nknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ate has page 2 2 No 2 No 1 Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lanol 600 North Wolfe St, Baltimore, MD, 21287 Ko taia omanus 32.. Registrar's Signature 31. Date filed, State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 09 Year Month Physician Wilson 26, Barbara August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Care 4b. City, Town, or Location of Death Examiner NA Baltimore Caton Manor Genesis Health | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10 - 10 - 40 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 69 220-36-8199 Director Usual Residence of Decedent 10b. County 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual to the traumatic event, the Medical Eventual to the filled at any injury or other traumatic event, the Medical Eventual to the filled at any injury or other traumatic event. Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3818 Bonner Road USA 21216 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. African Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Specify. ģ Specify: American 34 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th Grade College (1-4or 5+) Barbara Home maker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Eloise Baker Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph McNeil-Son 3818 Bonner Road Baltimore, Maryland 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 08-29-09 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signatule of Funeral Service License 638 N. Gilmor Street Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEART FAILURE **Physician** CONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events be executed and burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ☐Yes 2 No the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď STAGE RENAL DISEASE. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Division of Vital Records, or Attending

After

1 Yes 2 No

Certification: To 27. Manner of Death 1 Natural neral Director: , filled in by the f within 24 hours a

To the Funeral C

Medical

death.

the Hospital

29a. Certifier (Check only

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

3 Suicide

5 Pending investigation

6 ☐ Could not be

AUG 28 2009

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

28h Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 ☐ Yes 2 ☐ No

Do662634

RIDGE RD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

COL UMBIA

28d. Describe how injury occurred

4:30 AM

10d. Inside City Limits

Approximate Interval Between Onset and Death

FEW WEEK

FEW WEBKI

Year

MD 21644

1X Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifle August 26,21.4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICKURY

MATEEN AWAN 10802

Registrar's Signature

MA

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of H rtificate of L			erie g. No. 🦻 📋 📄	0 27622
Т			1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Yea	3. Time of Death
	Physicia /Medic		CHARLES T	ERRE V	VEBER			AUGUST 2	,	1:30 P M
	Examin		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Death		4c. County of De	eath
			1706 Cass Drive			Bel Air			Harfor	
	Funeral		5. Social Security Number 6. Sex	7. Age ( <i>i</i> n <i>yrs</i> .		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
	Director		216-32-8737	73	Yrs.			Dec. 24	<u>, 1935 M</u>	Maryland
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	sho	2	,							1 □Yes 2 No
	28a-f	Director	Maryland Harford  10e. Street and Number	Be	el Air	10f. Zip Code			g. Citizen of What	Country?
	a or					21015			JSA	·
	eath	era	1706 Cass Drive	2. Was Decedent Ever in U	S. 13. <sup>1</sup>		snanic Origin? (Sp			merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatils and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, Inc. Marcial Eventinal must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2⁄ू No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh Specify:	nite, etc. White
Maryland 21215-0036	hour tural	ed	15. Decedent's Educa		16a. Dece	dent's Usual Occupa	ation		6b. Kind of Busines	
12	in 72 n "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired,	luring most of work )	ing		
717	with giene r tha	E O	12	College (1-401 5+)	Draf	tman			State Hig	hway Admin.
ğ	othe /ent,	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
<u>Iar</u>	uld be Venta rked ric ev	10 E	John Charles Weber	r			Mae Eli	zabeth H	olland	
ar\	s ma		19a. Informant's Name/Relationship (Typ	•		ng Address (Street a				
Σ.	and and a salth n 27 her tra		Shirley J. Weber /			Cass Driv				
ore	of H of H if iter		20a. Method of Disposition  1√2 Burial 2 □ Cremation 3 □ Re	movel from State	cemetery, cřer	sition (Name of matory or other place	e) ¦		0c. Location - City	
altımore,	Pag ment ant:		4 Donation 5 Other (Specify)	Mt.		U.M. Chr.			el Air, M	Maryland
Ball	permit Depart Import any in	l. ly	21. Structure of Funeral Service License	Port	22 N	Name and Address ICCOMAS FU 50 W. Broa	is of Facility ineral Ho adway Be	me, P.A. 1 Air. M	D 21014	
П			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician	ě O	Immediate Cause (Final	Blecho r	rapi	-eric	222 /C	socie	rost	Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consec						
	Examiner		Sequentially list conditions b.							
-	ב פ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury	Due to (or as a consec	quence of):					1
	ecute ind trans	am	Cause (Disease or injury that initiated events c. resulting in death) Last							
Ö,	rtificate be executed ng physician and as the burial-transit	<u> </u>	resulting in dealth, Last	Due to (or as a consec	quence or):					
68760,	cate I	edical	d.							
×	ding l	/Me	IF FEMALE:	Bc. If yes, outcome of pregn	ancy	-			004 D-4- 4	delition.
ROX	eath certifi attending for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3[	Ectopic pregnancy Other (specify)	/		23d. Date of Month	Day Year
o	at the de by the a tached	ysic	1 □Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	deall 5L	Other (specify)				
<b>J</b> .	that t ed by detac		Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
SD	uires that signed I id be det	d by	Emphasema-					1 □ Ye	s 2 No 3	Probably -4 🗍 Unknown
Ö	w requir s been s should	Completed						24a, Was an	24b. Were	autopsy findings available
ě	has ge 2 g	mp						autopsy perform	prior death	to completion of cause of n?
ā	n: Th ficate r, pa		05.144					1 2 - 7 - 7		Yes 2□No
5	Physician: The la r this certificate haveral director, page 2	Be	25. Was case referred to medical examiner?	ospital:	155/6	et all pos Othe		th (Check only one	<u> </u>	2
0	Phy: r this ral di	Ę.	1 ☐ Yes 2 🛣 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	III 3 L DOA	4 LI Nursing H	28d. Describe ho	nce 6 Other (5	Бресіту)
0	ding Ph h. After thi funeral	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Worl	(? Yes 2 □No			
S	• Attence or death rector:	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	_l nome, farm, sti	reet, factory, office				r Rural Route Number,
Division of Vital Records,	pital or ours after ours after leral Dire	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	ity)			City or Town	, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Phys	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, deat ation and/or ir	th occurred at the time time the time t	me, date and place pinion, death occu	, and due to the carred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
	To the Hos within 24 hc To the Fun completely	Me	29b. Signature and title of certifier			29c. Licens	e number		d. Date signed (M	
	->F0		) s. Reaguer	oj. mis	>	20 0	EFEC	o C	8/24/	2009
			30. Name and address of person who cou				0 4 1000	5 1	sign no	D 21014.
			31 Date filed (Month Day, Year)	32. Registrar's Sign	ature 4		2 #100	- bel	ا) ما	5
	Sta Registr	ite ar	31. Date filed (Month, Pay, Year) AUG 28 20	09 Deneur	A. 1	barked				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 9:05 PM 25, Catherine Proctor Warfield August 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Air Year If Under 24 Hrs. Min. Harford Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Months 1 □ M 2X F 23, 1920 Maryland Dec. 216-12-6285 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Harford Bel Air Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 215 D Crocker Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates: White 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Elwood Proctor Bessie Irene Daughton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert C. Hess / Son 3316 Charles Street, Fallston, Maryland, 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 8/29/2009 Bel Air, Maryland 21. Signatur f Fune al Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. Mestly 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can ele on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): nceolia lope thy

**Physician** /Medical **Examiner** 

Physician

/Medical

**Examiner** 

10a. State

Director

by Funeral

Completed

Be

**Funeral** 

**Director** 

show

r than "natural", or items 23a or 28a-f sho

th and Mental Hygiene.
7 Is marked other than 'traumatic event, Inc. W.

permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other tra

in by the funeral

alcai Examine	Sequentially list conditions, if any, leading to finished attacase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. is chemic Caroliomy of Due to (or as a consequence of):	rufly
ysiciali/we	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
vollibleten by Fi	Part II. Other significant conditions of	herileanon, DMII,	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown  24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Ď	25. Was case referred to medical	26. Place of Death (Ch	eck only one)
2	examiner? 1 ☐ Yes 2 X No	Hospital: 1   DOA   Other: 4   Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
allon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Ďate of Injury (Month, Day, Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No	Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	1 28e. Place of injury - At nome, farm, street, factory, office	Location (Street and Number or Rural Route Number, City or Town, State)
- 1	29a Certifier 1X Certifying Ph	pysician. To the best of my knowledge, death occurred at the time, date and place, and	due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

m. D. 500 upper Che saparke Dr. Bel Air, Mo

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certified

within 24 hoi To the Fune completely fi

and manner stated.

leted cause of death (Item 23a) (Type, Print)

			For State	State	of Marylan		irtment of <i>tificate of</i>		Mental Hyg	jiene leg. No (-)		
			Registrar  1. Decedent's Name (First, Middle, Last	st)	<u></u>				2. Date of Dea	th I	115	3. Time of Death
	Physicia /Medic		Ella Louise Ward						August	25, 20	Year 109	3:59 A <sup>M</sup>
Ladar .	Examin		4a. Facility Name (If not institution, give	e street and n	umber)		4b. City, Town,	or Location of Dea	th	4c. Count	y of Death	
and a			Stella Maris Hos		1		Timon If Under 1 Year		Lo Balant Film		imore	
	Funeral Director		5. Social Security Number 6. S 216-14-3333	ex □M2 <b>X</b> 1F	7. Age (In yrs.		Months Days			(Year)	9. Birting Cour Oh.	place (State or Foreign htry)
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryia f sho	tor		٠.J								1 □Yes 2 🛣No
	r 28a-	Director	Maryland Harfor  10e. Street and Number	.u	ne	avre de	10f. Zip Code		1	l0g. Citizen of	What Cour	itry?
	th with		505 Congress Ave	enue			2107	8		USA		
	ems ems	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.\	Vas Decedent of f Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Ra	ce - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I'm Madical Examiner I, and be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, G Year or I	2 <b>∑(</b> No iive Dates:		□Yes 2MNo			Speci		
2-0	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed	)		lent's Usual Occi	upation during most of wo	rkina I	16b. Kind of E	Business/In	dustry
2	ithin ne.	mple	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	OO NOT use retir	ed)	,,,,,,g			
, D	filed w Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)			Hon	nemaker	18. Mother's Na	me (First, Middle,		Home me)	
Maryland	d be fental ked o	To Be	Rolland Augusta						Marie Cau		,	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (			19b. Mailir	g Address (Stree	et and Number or F	lural Route Numbe	r, City or Towr	ı, State, Zip	Code)
Ž	and 2		Gary R. Ward Sr.	/ Son	ι	P.C	). Box 8	2, Forest	Hill, M	aryland	1, 210	)50
altimore,	ges 1 t of He if iten or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other pl	ace)	Date	20c. Location	- City or To	wn, State
Ħ.	t. Pag tmeni tant: ilury o		4 Donation 5 ☐ Other (Specification 5 ☐ Other	y)				Gdn. 8/2				Maryland
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licer	see A			. Name and Add	ress of Facility Sbury Ro	McComas : ad, Abin			•
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plication / hat one cause on	caused the deat							Approximate Interval Between
	Physician		Immediate Ceuse (Final disease or condition	a. END	STAGE RE	NAL DI	SEASE					Onset and Death
	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	quence of):						
		Jer	Sequentially list conditions, if any, leading to immediate	b	o (or as a conseq	uence of):						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.								
, 0	icate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to	o (or as a conseq	uence of):						
38760,	icate be executed physician and s the burial-transit	dical		d				-			+	
Вох	leath certifi attending   for use as		IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d. D	ate of deliv	ery
Ö.	death ne atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No		e birth 2 Teta gnant at time of a		Ectopic pregnal Other (specify)	ncy		N	lonth	Day Year
P.O.	at the ded by the etached	Phys	9 Unknown			100 000	1.12		OO a Diel to			he cause of death?
Records,	law requires that the death certif as been signed by the attending 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to	death but not res	suiting in the ui	aderiying cause g	iven in Part I.	1 □ Y	. 34.0		pably 4 Unknown
CO	aw requir s been s should	olete							24a. Was a		. Were auto	ppsy findings available
<u> </u>	The ate h	Completed							autop perfor 1 □ Yes	med?	prior to co death? 1 🗆 Yes	mpletion of cause of 2 □ No
Vital	clan: sertific	Be (	25. Was case referred to medical examiner?						eath (Check only or			
of \	Physi r this o		1 ☐ Yes 2 🛣 No 27. Manner of Death	_	Inpatient 2  e of Injury	ER/Outpatier	I 3 L DOA					MOSPICE
uo	ding P h. After funer	tion	1 Natural 5 ☐ Pending	(Mo	onth, Day, Year)	Injury	W W	uryat ork? ⊡Yes 2⊡No	28d. Describe h	ow injury occu	rred	
Division	i or Atten after deatl Director: I in by the	ifica	3 Suicide 6 Could not be	28e. Plac	e of Injury - At h	ome, farm, str	eet, factory, office		28f. Location (S	treet and Num	ber or Run	al Route Number,
ă	pital or ours afte eral Dire	Certification: To	4 Homicide	DUH	ding, etc. (Speci	ny)			City or Tow	n, State)		
	Fun Fely	edical	(Check only 2 Medical Exar	niner: On the	basis of examina			time, date and place opinion, death occ				
	To the Hos within 24 hd To the Fun completely	Mec	oneX Nurse Pract  29b. Signature and title of pertifier	TUTOHE	Liner stated.		29c. Lice	nse number		29d. Date sign	eq (Month,	Day, Year)
	->-0		> 14AM	RA.	NP		RI	49797		8/25	/200	a
			30. Name and address of person who	completed car	use of death (Iter	m 23a) (Type,	Print)					
			JACKIE JONES, C				LLEY RD.	TIMONI	UM, MD 21	.093		
	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa	A. A.	arked					

DHMH 17 Rev 1/2001

3:59 а.т.

AUGUST 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5 17 D18 per FH G8 95 2/3/09 WS State of Maryland Department of Health and Mental Hygiene per Fh g8 97 11/6/09 Tiffcate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** 404 AM Wat Name /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Examiner of Mar-Medicer Baltimore Universit MD 16ms If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1**X**M 2□ F Director April 29,1948 218-46-9181 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Experiment must be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No Baltimore Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21307 Garden USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 M Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NG use retiretly Guard 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Security Elementary/Secondary (0-12) College (1-4or 5+) 13 Driver transporter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnamey3♥ Be Estella Lane James W. Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD ZIZ31 BaHo, Himore Watkins / son 20inten 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 8-31-09 4 ☐ Donation 5 ☐ Other (Specify) letro Crematory 8 Baltimore, MD 21. Signature of Francial Pervice Lin-188 ILAM 1222 Midvalley Dr Jessup, PA 18434 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Zause (Final disease or condition resulting in death) Physician Dissection ANTIC Ascending /Medical Due to (or as a consequence of): tension Examiner cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No Was an autopsy performed? 24a. Was an 1 ☐ Yes Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation within 24 hours after death,

To the Funeral Director: A
completely filled in by the fu 1 ☐Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Sto Ballimore 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 28

		1 - For State Of 1 - State Registrar	-	epartment of H Certificate of L			ene . No. 2   1   1   9	2762
Physici /Medic		Decedent's Name (First, Middle, Last)     Joseph M. A.	ntonelli		,	2. Date of Death Month August 13	Day Year <b>, 2009</b>	3. Time of Death <b>7:10 a</b> M
Examin Funeral Director		577-50-1413 1≅ M 2□ F	er) Age (In yrs. last birthd Yrs <b>71</b>	lay) If Under 1 Year Months Days	thesda If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	tgomery place (State or Foreign ntry) ict of Columbi
e Maryland Ba-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery	10c. City, Town or		thesda			10d. Inside City Limits 1 ☐ Yes 2 🗷 No
ath with the 23a or 23		10e. Street and Number 4921 Earlston Drive			20816		Citizen of What Cou	Α.
s 1 and 2 should be filed within 72 hours after death with the Maryland st 1 and 2 should be filed within 72 hours after death with the Maryland if the Bith and Mental Hygiene.  The marked other than "natural" or items 23a or 28a-f show other traumatic event, I'm Mudical Evaniner must be notified at	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	₹ No s:	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No ecedent's Usual Occupa	Specify:		14. Race - Ameri Black, White, Specify: b. Kind of Business/In	etc. White
of 2 should be filed within 72 hours aft tilth and Mental Hygiens 17 is marked other than "natural", or traumatic event, In Medical Evanni	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c  4  17. Father's Name (First, Middle, Last)	(G	ive kind of work done di fe. DO NOT use retired)  Civil Eng	uring most of work	ing	Engine	
should be fi and Mental H marked ot umatic ever	To Be	Nick V. Antonelli  19a. Informant's Name/Relationship (Type. Print)	10h 11			Pearl Ga	ch	n Codel
1 and 2 sl Health an em 27 is r ither traur		Margaretha Antonelli - Wife  20a. Method of Disposition	4	ailing Address (Street a  921 Earlston  sposition (Name of	Drive, Bet	hesda, Mary		
Page nent c ant: If ury or		1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Judean M	sposition (Name of crematory or other place	ns   08/14	4/2009	Olney, A	
permit. Departi Imports any Inji		21. Signature of Funeral Service Licensee MO129  23a. Part 1. Enter the disease, or complications that cause		22. Name and Address Hines-Rinaldi 11800 New Ham	Funeral Hepshire Ave	nue, Silver		yland 20904  Approximate Interval Between
Physician /Medical Examiner  be be oxecuted  by the prijet fransit  streep the prijet fransit  by the prijet fransit  control of the prijet fransit  contro	edical Examiner	resulting in death)  Due to (or a Due to (or	inoma of Unkn as a consequence of): as a consequence of): as a consequence of):	nown Primary S	ite			Onset and Death  10 months
death certif e attending d for use as	Physician/Me		n 2  Fetal death t at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	ery Day Year
The law requires that the date has been signed by the page 2 should be detached	è	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause give	n in Part I.		cco use contribute to t	he cause of death?
in: The law re ificate has bee or, page 2 sho	Completed	25. Was case referred to medical				24a. Was an autopsy performed	prior to co d? death?	opsy findings available impletion of cause of
hysi this c	Certification: To Be	examiner?  1	atient 2 ER/Outpa njury 28b. Time Day, Year) 28b. Time Injury - At home, farm, etc. (Specify)	tient 3 DOA Other e of 28c. Injury Work? M 1 Y	r: 4 □ Nursing Ho at es 2 □ No	28d. Describe how	et and Number or Rura	
Hospital o	Medical Cer	29a. Certifier  (Check only  1 ▼ Certifying Physician: To the besident of the performance of the performanc	st of my knowledge, de	eath occurred at the tim r investigation, in my op	e, date and place, inion, death occur	and due to the cau	se(s) and manner as	stated. o the cause(s)
Z To the Z Within 2 To The C Complete		29b. Signature and title of certifier  30. Name and address of person who completed cause of	mg	29c. License		29d	Date signed (Month,  August 13, 2	Day, Year)
Stat Registra	e	Ralph Boccia, M.D., 6420 Ro		e, #4100, Bet	hesda, Mary	yland		

			Please		aryland / D	c Indelible Info epartment of	Health and I	-	_	ble.	27627
	Physici /Medio	al	Decedent's Name (First, Middle, Lateral Galila     Galila  4a. Facility Name (If not institution, giv.)	Aly		Certificate of	4b. City, Town, or	2. Date of Dea Month 8-15-	Day	Year	3. Time of Death 3:00pm
	Examir Funeral Director	ier	7105 Sonnett C 5. Social Security Number 6. S	t.	e (In yrs. last birti 2	hday) If Under 1 Yea Months Days	Derwo	od	Mont	gomei	e (State or Foreign
		ector	Usual Residence of Decedent	ery	10c. City, Town	erwood				10d.	Inside City Limits
	death with the ms 23a or 2	Funeral Director	7105 Sonnett C	12. Was Decedent I	Ever in U,S.	10f. Zip Code 2085  13. Was Decedent of If Yes, specify Cul				e - American	Indian,
5-0020	4 within 72 hours after death with the Marylan liene. r then "neturel", or Items 23a or 28e-f show the Madical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced  15. Decedent's Ec	Armed Forces? 1 ☐ Yes 2 CM If Yes, Give Year or Dates:		1 ☐ Yes 2 📆 No	Specify:		Specify  16b. Kind of Bu		nite
1717	e filed within 72 hours after death with the Maryland Il Fygiene. other then "neturel", or Items 23a or 28e-f show vent, the Medical Exercites must be notified at	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12	de completed)  College (1-4or 5	+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retir Homemaker	-,		Home	<u> </u>	ury .
Maryland	should be nd Mental marked o	To Be	17. Father's Name (First, Middle, Last) Aly Abdelrahma  19a. Informant's Name/Relationship (			Mailing Address (Stree	Mabro	ne (First, Middle, I uka Shi ural Route Numbel	bl You	ssef	ode)
altimore, Ma	permit. Pages 1 and 2 Depertment of Health a Important: If item 27 Is eny injury or other tra		Nagwa Abutaleb  20a. Method of Disposition  1 CMBurial 2 Cremation 3 C	Removal from State	20b. Place of cemetery	05 Sonnet Disposition (Name of v, crematory or other pla	ace)	Date	20c. Location -	City or Town	
Baitin	permit. Pa Depertmer Important: eny injury once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Ft. L	incoln Ce 22. Name and Addr 411 Kenn	ress of Facility U	niversa	1 Mort	uary	
)	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each lin						A	oproximate terval Between nset and Death
	Examiner	Examiner	resulting in death)	b	Due to (or as a c	,				£ 1 1	
68/60,	eath certificate be executed attending physician and for use es the burial-transit	edical Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulung in deain) Last	C	Due to (or as a c						
POX	000	Physician/Me	Part II. Other significant conditions or	d	t not resulting in	the underlying cause g	iven in Part I.	23b. Did to	bacco usa cor	ntributa to th	a causa of death?
as, r.o	requires that the des neen signed by the a hould be deteched f	ρ						1 □ Y 24a. Was a	es 2 No		autopsy findings
ı necoras,	The law ite has b page 2 s	Completed						perform	med?	availa comp of dea	ble prior to letion of cause
VII.a	Physicien: The	æ	25. Was case referred to medical examiner?	Hospital:		_  0	ther:	ath (Check only on			
0 10	ling Phys The After this funeral di	atlon: To	1  Yes	28a. Date of Injur (Month, Day	y 28b. Ti	me of 28c. Injury	4 Li Nuising H	lome 5 Reside 28d. Describe ho			
DIVISI	Ital or Atte irs efter de rel Directo lled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulding, etc	ry - At home, far (Specify)	m, street, factory, office	•	28f. Location (Si City or Town		er or Rural R	oute Number,
	To the Hospital or Attenc within 24 hours efter deati To the Funerel Director: completely filled in by the	Medical			examination and	death occurred at the t /or investigation, in my 29c. Licen		rred at the time, d		and due to th	e cause(s)
	+ 3 F 8 5		30. Name and address of person who o	completed cause of de	ath (Item 23a) (1		7258		8-16-0		
_	ろ Sta	te	Nicholas Farrel 31. Date filed (Month, Day, Year)  AUG 17 2009	1 M D 32. Registra	9903 's Signature	Medical C	enter D	r., Roc	kville	MD	20850
	Registr	ell.	MUU I I EUUS Z	and p	7						

DHMH 16 Rev 6/95

3 X Widowed 4 ☐ Divorced

Funeral

Completed by

Be

မ

Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

**Physician** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending hospidage and

After this certificate has been signed by the atte funeral director, page 2 should be detached for i

filled in by the

completely

Box 68760.

P.O.

Division of Vital Records,

/Medical Examiner

burial-transi

USA

14. Race - American Indian, Black, White, etc.

h		3. Time of De	ath
12.	2009 Year	6:36 a	N

4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Days

8. Date of Birth (Month, Day, Year Aug 20, 1 73 1935 Maryland 10d. Inside City Limits 10c. City, Town or Location

Certificate of Death

1 X Yes 2 □ No Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157

26 Pennsylvania Avenue Apt 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married

1 ☐Yes 2 No Specify white Specify: 16a. Decedent's Usual Occupation

2. Date of Deat

August

16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Custodian

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachel Smith Paul R. Shaffer

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Pennsylvania Ave Apt 1, Westminster, MD 21157 Donald E. Shaffer, son

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/15/2009 Westminster, MD Meadow Branch Cem 4 Donation 5 Other (Specify)

22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157

23a. Part. Enter the disease, or complications that cas ock, or heart failure. List only one cause in ea Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dvi , such as cardiac or respiratory arrest, Immediate Cause (Final

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No

3 Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown

23d. Date of delivery Month Year

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 2 100 1 ☐ Yes

25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? + ☐ Natural 5 Pending investigation

1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one)

29b. Signature d title of certifier

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

Westminster 31. Date filed (Month, Day, Year)

State Registrar

32. Registrar's Signature AUG 1

WJZ 3

			For State Registrar	state of Maryla	•	rtificate of L			g. No.	19	2/629
	Physici	on.	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic		William Bruce Altho					8/9	/2009		2330 <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give stre Anne Arundel Medical				Location of Death		4c. County of		de1
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In )	vrs. last birthday) 84 Yrs.	If Under 1 Year  Months Days	-	8. Date of Birth (Month, Day, 3/6/192	Year)		lace (State or Foreign try)
	pu »		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Loc	oation					0d. Inside City Limits
	e Maryla ta-f shov	ctor	MD Anne Arus		Annapo						1 □Yes 🎇 No
	3a or 28	al Dire	10e. Street and Number 7101 Bayfront Dr. #4	420		10f. Zip Code	21403	10	g. Citizen of W	hat Coun	try?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Eventiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	Was Decedent Ever in Armed Forces?  1XXYes 2 □ No V: If Yes, Give Year or Dates:	ietnam	Was Decedent of Hi f Yes, specify Cuba I □Yes 2 <sup>X</sup> No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	r, White, ε	an Indian, atc. hite
21215-0036	n 72 ho "natur edical	Completed	15. Decedent's Educati (Specify only highest grade co		(Give	dent's Usual Occupa kind of work done of OO NOT use retired	luring most of work	ing 1	6b. Kind of Bu	siness/Inc	dustry
212	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the M	Som C	Etementary/Secondary (0-12)	College (1-4or 5+) 4	7,700	Officer			US_	Navy	
pu	be file tal Hy d othe event,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		laiden Surnam	e)	
Maryland	ould to marke narke	오	William Althoff				Mary 1		O': T		
Ma			19a. Informant's Name/Relationship (Type. Marilynn Althoff	Spouse		ng Address <i>(Str</i> eet a Bayfront					
re,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	20		sition (Name of natory or other place			20c. Location -		
Baltimore,	Page ment ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	loval from State	tlantic	Crematory	8/12	/2009	Glen Bu	rnie	, MD
Ball	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee		12	Name and Address	ss of Facility Han Ave. Ann	rdesty Fr napolis,			, P.A.
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the d							Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition resulting in death)		Darkin	non					Onset and Death
The state of	/Medical Examiner			Due to (or as a con-	sequence of):						
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):						
oʻ	tificate be executed g physician and es the burial-transit	Exan	that initiated events c resulting in death) Last	Due to (or as a con-	sequence of):					_	
68760,	cate be ohysicia the bu	edical	<b>C</b> d							_	
O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending principles, page 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy	1		23d. Dati Mor	e of delive	ery Day Year
ds, P.	uires that n signed b Id be deta	þ	Part II. Other significant conditions contrib	outing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob			ne cause of death?
of Vital Records,	: The law requir cate has been s , page 2 should	Completed						24a. Was ar autops	v l p	Vere auto	psy findings available mpletion of cause of
tal	ician: Th certificate ector, pag		25. Was case referred to medical		<del></del>	·	26. Place of Deat	1 ☐ Yes 2	No 1	□Yes	2 □No
fνi	nysician: nis certific director, p	To Be	examiner? 1 ☐ Yes 2 ☑ No Hos	pital: 12 Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA Othe	ar.	ome 5 Reside		er (Specif	y)
o u	d <b>ing Ph</b> h. After th funeral	ion:	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	r) 28b. Time of Injury	Work	(?	28d. Describe ho	w injury occurre	∍d	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. <i>(Sp</i>	At home, farm, streecify)		Yes 2□No	28f. Location (Sti	reet and Number, State)	er or Rura	al Route Number,
	spital		29a. Certifier 1 Certifying Physic								
	he Ho in 24 h he Fu ipletely	Medical	(Check only 2 Medical Examiner one)	on the basis of examand manner stated.	nination and/or in	vestigation, in my o	pinion, death occur				
	To the within 2 To the complete	Σ	29b. Signature and title of certifier			29c. License	SJ 13 (		od. Date signed		Day, Year)
			30. Name and address of person who comp	oleted cause of death (	(Item 23a) (Type,					40/	
J.	14218		CO-) J Sprint	33 1108 17	12 ont	In we	167 B-	mo 7	419		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 12 20	32. Registrar's Si	griature.	pare					

Registrar DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		ryland / Depa <i>Cei</i>	rtificate of L	Death		g. No. 7 A A C	27630
			Decedent's Name (First, Middle, Las	<i>t</i> )				Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic		Kathryn Rose	Ander	son			August 7		11:30 P. <sup>M</sup>
and the same	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	th
			Magnolia Center			Lanham If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Prince G	eorge's thplace (State or Foreign
	Funeral		5. Social Security Number 6. Security Number 11	ex	(In yrs. last birthday)  6 Yrs.	Months Days	Hours Min.	(Month, Day, 9/27/19	Year) Co	niplace (State of Foreign nuntry)
	Director		Usual Residence of Decedent					9/2//19	ZZ FILI	mesoca
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-f s	cto	Maryland Prince G	eorge's	Bowie					1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?
	ath w		12700 Clearfield			20715	inneria Origina (Co		14. Race - Ame	orican Indian
	er de item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🔀 No	verin u.s.	Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White	
336	Irs aff	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 <b>X</b> No	Specify:		Specify: Wh	nite
5-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must be rediffed at	ted	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	ation	ina 1	6b. Kind of Business/	/Industry
21	within 7 liene. r than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	) 1	kind of work done of DO NOT use retired		, , ,	Grocery	
21	filed wi Hygier other th		12		Be	ookkeeper	18. Mother's Name	(First Middle M	Store	
Maryland	ould be fi Mental I- arked ott atic ever	Be	17. Father's Name (First, Middle, Last)  Joseph Hundt				Louise	Mayer	and on Carriamo,	
ξ	should and Mer is marke aumatic	ဥ	19a. Informant's Name/Relationship (7	Type Print)	19b. Mailir	na Address (Street			City or Town, State, .	Zip Code)
Z	nd 2 Ith 8 27 is		Richard Anderson/S		1	•			Maryland	
ē,	ges 1 and 2 t of Health If item 27 i or other tra	1	20a. Method of Disposition		20b. Place of Dispo cemetery, cree				Oc. Location - City or	
E	Parit F		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State /)		Cremator	1 - 1 - 1 -	:009   G	len Burni	e, Maryland
Baltimore,	arta arta inje		21. Signature of Funeral Service Licen	see	22	2. Name and Addre	ss of Facility Rob	ert E. E	vans Fune:	ral Home,
<u> </u>	Dep Imp		1 fell there	5					, Marylan	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused to one cause on each line	the death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS						3-4 WEEKS
	/Medical Examiner		resulting in death)		consequence of):	1000				2-4 house
		e	Sequentially list conditions, if any, leading to immediate	b. Decubling Due to (or as a	consequence of):	-CCL			V.	7 -( - 00 - 00 - 00 - 00 - 00 - 00 - 00
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	CHRONI	IC OBS	TRUCTIV	e Puli	MONARY	DISCARE	UNKNOWN
o,	an an		resulting in death) Last		consequence of):					UNKNOWN
68760,	ificate be executed g physician and is the burial-transit	edical		d HYPERT	TENSION					3-4 WEEKS UNKNOWN UNKNOWN
	±	Ĭ,	IF FEMALE:	OGo If you gutcome o	1153					
Box	eath certifi attending for use as	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	·y		23d. Date of de Month	Day Year
o.	ires that the de signed by the a l be detached f	Physician/M	1 □ Yes 2 ZHNuo 9 □ Unknown	9 ☐ Unknown	umo or douting of					
σ,	that hed b	늅								
7		>	Part ii. Other significant conditions o	ontributing to death but	t not resulting in the u	ınderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
7	quires an sign uld be	ed by	Part II. Other significant conditions o	ontributing to death but	t not resulting in the u	ınderlying cause giv	en in Part I.			to the cause of death?
ecor	aw requires as been sigr 2 should be		Part ii. Other significant conditions o	ontributing to death but	t not resulting in the u	inderlying cause giv	en in Part I.	1 ☐ Ye	s 2 No 3 F	Probably 4 Unknown
l Record	The law requi ate has been bage 2 should		Part ii. Other significant conditions o	ontributing to death but	t not resulting in the u	inderlying cause giv	ren in Part I.	1 ☐ Ye  24a. Was ar autops	s 2 No 3 F	Probably 4 Unknown
/ital Record	cian: The law requires ertificate has been sign ector, page 2 should be	Completed	Part ii. Other significant conditions of the con		t not resulting in the u		26. Place of Deal	1  Ye  24a. Was ar autops perform 1  Yes 2	24b. Were a prior to death?	Probably 4 Unknown utopsy findings available completion of cause of s 2 \( \sqrt{No} \)
of Vital Record	Physician: The law requires this certificate has been signal director, page 2 should be	To Be Completed	25. Was case referred to medical examiner? 1 □ Yes 2 KNo	Hospital: 1 ☐ Inpatier	nt 2 ⊟ ER/Outpatie	int 3□ DOA Oth	26. Place of Deal	1  Ye  24a. Was ar autops; perform 1  Yes 2 ch (Check only one	24b. Were a prior to death?    A	Probably 4 Unknown utopsy findings available completion of cause of s 2 \( \sqrt{No} \)
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	g Physician; er this certificieral director, p	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Hospital: 1 ☐ Inpatier  28a. Date of Injur (Month, Day)	nt 2 □ ER/Outpatie y 'Year) 28b. Time o Injury ry - At home, farm, st	ent 3 DOA Oth of 28c. Injur Wor M 1	26. Place of Deal	1  Ye  24a. Was ar autops: perform 1  Yes 2 th (Check only one 28d. Describe ho  28f. Location (St.)	24b. Were a prior to death?  24b. Were a prior to death?  1 Ye  20  20  20  20  20  20  20  20  20  2	Probably 4 Unknown utopsy findings available completion of cause of s 2 No
	g Physician; er this certificieral director, p	To Be Completed	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier  28a. Date of Injur (Month, Day)	nt 2 □ ER/Outpatie y 'Year) 28b. Time o Injury ry - At home, farm, st	ent 3 DOA Oth of 28c. Injur Wor M 1	26. Place of Deat ler: 4 Nursing Hory at k?	1 Ye  24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho	24b. Were a prior to death?  24b. Were a prior to death?  1 Ye  20  20  20  20  20  20  20  20  20  2	Probably 4 Unknown utopsy findings available completion of cause of s 2 No
	g Physician; er this certificieral director, p	Certification: To Be Completed	25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigation investigation   3   Suicide 4   Homicide   Homicide   Certifying Ph	Hospital: 1 Inpatier  28a. Date of Injury (Month, Day,  28e. Place of Injury building, etc.	nt 2 □ ER/Outpatie y Year) 28b. Time of Injury ry - At home, farm, st. (Specify)	ont 3 DOA Oth of 28c. Injur Wor M 1 Dreet, factory, office	26. Place of Deal ier: 4 Nursing H ry at k?  Yes 2 \ No	24a. Was ar autops: perform 1   Yes 2 th (Check only one 28d. Describe ho 28f. Location (St. City or Town	24b. Were a prior to death? 24b. Were a prior to death? 24c. Were a prior to death? 1 Ye  25c. Were and Number or F., State)	Probably 4 Unknown utopsy findings available completion of cause of s 2 No ecity)  Rural Route Number, as stated.
	g Physician; er this certificieral director, p	Certification: To Be Completed	25. Was case referred to medical examiner?  1   Yes 2   No  27. Manner of Death  1   Natural   5   Pending investigation   3   Sulcide   6   Could not be determined  29a. Certifier (Check only one)	Hospital: 1 Inpatier  28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.	nt 2 ER/Outpatie y year) 28b. Time of Injury ry - At home, farm, st. (Specify)  If my knowledge, dea examination and/or in	ont 3 DOA Oth of 28c. Injun Wor M 1  reet, factory, office th occurred at the tinvestigation, in my of	26. Place of Deal ler: 4 Nursing Hory at K? Yes 2 No	1 Ye  24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho  28f. Location (Str. City or Town, and due to the corred at the time, di	24b. Were a prior to death? 1 Ye 29) nnce 6 Other (Spin winjury occurred  reet and Number or Fin, State)  ause(s) and manner after and place, and during the state of the stat	Probably 4 Unknown utopsy findings available completion of cause of s 2 No ecity)  Bural Route Number, as stated. le to the cause(s)
	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	To Be Completed	25. Was case referred to medical examiner?  1	Hospital: 1 Inpatier  28a. Date of Injury (Month, Day)  28e. Place of Injury building, etc.  1. To the best of miner: On the basis of and manner state	nt 2 ER/Outpatie y year) 28b. Time of Injury ry - At home, farm, st. (Specify)  If my knowledge, dea examination and/or in	ont 3 DOA Oth of 28c. Injury Wor M 1 creet, factory, office th occurred at the tinvestigation, in my of	26. Place of Deal ler: 4 Nursing Hory at K? Yes 2 No lime, date and place opinion, death occur se number	24a. Was ar autops: perform 1 Yes 2 th (Check only one 5 Reside 28d. Describe ho 28f. Location (St. City or Town, and due to the circed at the time, di	24b. Were a prior to death? 1 Ye 29) nnce 6 Other (Spin winjury occurred  reet and Number or Fin, State)  ause(s) and manner at and place, and dualed.	Probably 4 Unknown  utopsy findings available completion of cause of s 2 No  ecify)  Bural Route Number,  as stated. te to the cause(s)  oth, Day, Year)
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2009 AUGUST **GLADYS** ALLEN al MARIE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CIVISTAMEDICALC ENTE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🕱 F Director TUL. 13.1931 MASSACHUSETTS 010-24-0896 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show the Medical Examiner must be notified at **X**Yes 2 □ No Director CHARLES LA PLATA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 THOMAS JEFFERSON STREET 20646 U. S. A. 116 Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 id Mental Hygiene. marked other than College (1-4or 5+) LIFE SERVICE REPRESENT. LIFE INSURANCE CO. permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygier Important: if item 27 Is marked other it any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAROLYN ANN HICKEY WILLIAM J. NOLAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 116 THOMAS JEFFERSON ST., LA PLATA, MD 20646 JAMES P. ALLEN /HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State ALEXANDRIA, VA METRO. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee cry M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of Examiner atro Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examine physician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical attending p for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the 1∐Yes 2∐No 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 ☐ Yes 2 No 1 □Yes 2 the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death After 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 □Yes 2 □No after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral I 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatore and title of certifier

Registrar

State

Ivinoption Rd.

PPICE

Ford Washington, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

man

31. Date filed (Month, Day, Year)

AUG 28 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 2009 **Physician** tor 740 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Nursing and Rehab Burtonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign NY intry) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 ☐ M 2 ☐ XF Days Hours Min 0570*57*1919 90 085-05-3023 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Howard Columbia 1∰Yes 2∏No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9469 Hundred Drums Row 21046 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify ò Specify: Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Zarovsky Rose Dosik 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9451 Keepsake Way Columbia MD 21046 Gail Zinar - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ARemoval from State King David Memorial Gardens 4 Donation 5 Dother (Specify) 08/14/2009 Falls Church, VA 21. Signature of Eunoral Service Licensee Banzanek Gerofithers Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 M01163 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mecmonia Due to (\* as a consequence of). disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 X No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð tractive 1 🗌 Yes 2□ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **2** No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

certificate be executed signed by the aftending physician and d be detached for use as the burial-transit Box 68760 P.O. I Division or Vital Records, page 2 s After this certificate or Attending Physician: director,

28a-f show ä

r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified

"natural", or

Is marked other than

permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the M

within 72

Baltimore, Maryland 21215-0036

Certification:

29a. Certifier

(Check only one) 29b. Signature

5 ☐ Pending investigation 2 Accident 3 ☐ Suicide 4 Homicide

d title of certifier

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

xux 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year) Reesterstown

Registrar

Medical

25 Secey 31. Date filed (Month, Day, Year) Registrar's Signatu 14 AUG

Marin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours after death,

To the Funeral Director: Af
completely filled in by the fur

the Hospital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 08 08 1038 M 2009 Ludovic Beauge /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner mon 1701 East WA Silver 11.77 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 11☑ M 2□ F Director 579-52-6914 92 Haiti 2/17/1917 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1XYes 2 No Director MDMontgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1701 East West Highway 20910 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: African ٥, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ 3 Widowed 4 ☐ Divorced 'natural", American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kennedy Warren Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M unk Apt. Bldg. Porter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dugur Beauge Marence Francois 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 Dominique Beauge/Son 1701 East West Hwy., Apt.G-18 Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. 8/15/2009 4 ☐ Donation 5 ☐ Other (Specify) SIlver Spring, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service License 7400 Georgia Avenue, NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) SYA /Medical Due to (or as a content nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ Yes 2□ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ECKEX mo

Registrar

31. Date filed (Month, Day, Year)

AUG 14 2009

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State Registrar

Jawad Arshad,

9901 Medical Center Drive M.D32. Registrar's Signature

Rockville, MD 20850

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Mont8/7/2009 Year 3:00am **Physician** Miriam Brathwaite /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Pasadena Pasadena Home Care 8. Date of Birth (Month, Day, Yo 7/2/1917 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Min. Months Days Hours Panama 92 Yrs. 1 M 245x F 217-51-4017 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinator must be notified at 1 ☐ Yes XXNo Director MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21144 Panama 1851 Eagle Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** Specify: Panamanian Baltimore, Maryland 21215-0036 1XWes 2□No Specify. 2 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglene Important: If item 27 Is marked other that any injury or other traumatic event, its once. Housewife Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK Ernestine Abraham Layne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eagle CT. Severn, MD Janice Rice Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Epiphany Cemetery 8/16/2009 Odenton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hardesty Funeral Home, P.A. 1 Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Par Physician m /Medical Due to (of as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 Ne7 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 NO 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Lother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA dire 1 | Yes 2 | 1 | Vo this Certification: To 28a. Date of Injury (Month, Day, Year) 28d Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Aftert 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Acciden 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Made 31. Date filed (Month, Day, Year) 32. B#0 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For AMEND#28C per PHY
State of Maryland / Department of Health and Mental Hygiene
1- Registrar 8/12/09 AACO HEALTH DEPT. CMH
Certificate of Death
Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 12:10PM August Charles Bloomer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Unit 118 1103 Smithville St. Annapolis If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, DeC 31 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year 939 Hours Min. 1 M 2 □ F Maryland 69 220-38-7023 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 23a 21401 USA Funeral 1103 Smithville St. Unit 118 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo 3 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11thO Truck Driver Cement Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin J. Bloomer Henrietta Dean ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau Joyce A. Bloomer(Daughter) 803 Arch St. Norristown, PA. 19401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-11-09 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Minimame Reverse of SeciliBons Mortuary, 821 West St. Annapolis, Md. 21401 M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 I Unknown signed by t the detach 23e. Did tobacco use contribute to the cause of death? Parhil, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 ☐ Yes funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Natural 5 Pending investigation neral Director: A filled in by the fu 1 Yes 2 1 death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and add

31. Date filed (Month)

person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

William Barnaby Berard, III

2009 27637

	R	For State		Certifica	ite oi	Dealli					eg. No.		
Physicia ledical Examin	n/ 1	. Decedent's Name (First, Middle,Las William Barnaby						2. Date of Death Month Day Yea August 21, 2009			3. Time of Death 0955 hrs		
	4	Facility Name (if not institution, give street and number)     Hillsmere Drive					Annapolis				Anne A	rundel	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 1 X M 2 F 45 Yr					1 Year Days	If Under 2 Hours		8. Date of Bi		hplace (State or Foreign Intry) hington, D.C.	
,	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Locat	ion		-					10d. Inside City Limits
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daryland 28a-f show	Director	10e. Street and Number	-	U					Citizen of What Country?				
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th wit	uneral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces?		13. Wa	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						ite, etc.	
ter dea	ᄔᆝ	3 Widowed 4 X Divorced	1 X Yes 2 If Yes, Give Year 198	№ 84 <b>–</b> 89	1	Yes 2	No	specify:			Specify	/: Wh	nite
ours af	핡	15. Decedent's Education (Specify o	l or Dates: nly highest grade con	opleted) 16a.	Deceder	nt's Usual O	ccupatio	n (Give kir	nd of wor	rk done	16b. Kind of	Business/	Industry
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Complete	Elementary/Secondary (0-12)	_	ty Cor					Ryder	Ryder Corporation			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	탕	17. Father's Name (First, Middle, Last	)								Maiden Surnar	ne)	
215 be file antal H rked o	B	William B. Berard								e Har		State	Zin Codo)
O 21 should and Me is ma	₽[	19a. Informant's Name/Relationship ( Mary Lynne Berar								er, City or Town, State, Zip Code) , Maryland 20832			
, MD and 2 sho ealth and tem 27 is traumati	-	20a. Method of Disposition	d/Hother	20b. Place	of Dispo	sition (Name		_		Date			Town, State
Baltimore, permit Pages I an Department of Hee Important: If ite	ı	1 X Burial 2 Cremation 3		ale		ther place) Garde	ns		8/2	6/09	Arlin	ngton	. VA
Iltin	+	4 Donation 5 Other Specify 21. Signature of Funeral Service Lice			22.	Name and A	Address	of Facility	Geor	ge P.	Kalas	Funer	al Home
Dep perm		Illuc -											, MD 21037
Physician		23a. Part I. Enter the disease, or com failure. List only one cause on e	ach line										Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco		2 F	etal death	3 [	Ectopic	pregnar	псу	Mont		Day Year
Box e death c the atten	Physicia	1 Yes 2 No 9 Unknow	3 31					ives in Par	et I	23e Dio	tobacco use co	ontribute t	o the cause of death?
P.O. Box 68 es that the death certi igned by the attendim or detached for use as	by P	Part II. Other significant conditions  Cardiomyopath											obably 4 Vunknown
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COT law re has be	nple									pei	topsy rformed? s 2 ✔ No	death?	
Re It The ifficate		25. Was case referred to medical					26.Place	of Death (	(Check o		3 2 0 110		
/ital	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2 ER/0	Outpatie	nt 3 D	ЮА	Other <sub>4</sub>	Nursing	g Home 5	Residence	6 🗸 Oth	er: Scene
Division of Vital Records, tal or Attending Physician: The law requir 1s after death.  al Director: After this certificate has been sied in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	n: To	27. Manner of Death	28a. Date of In (Month, Day	jury 28b (Year)	. Time o	f Injury		ry at Work′ res 2		28d. Describ	e how injury oc	curred	
ision Attendi or death. rector: by the f	atio	2 Accident Pending	ation	Injury - At home,	form of	Tool footon				28f Location	n (Street and N	umber or F	Rural Route Number, City
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Fo the Hospit within 24 hour To the Funeri	Medical Ce	4 Homicide  29a. Certifier 1 Certifying Physone) 2 Medical Examin	cian: To the best of er:On the basis of ex	amination and/or	eath occ	curred at the	time, da y opinion	ate and pla	curred a	due to the ca t the time, da	ause(s) and ma ate and place, a	nner as st nd due to	ated. the cause(s)
To t	Med	29b. Signature and title of certifier	and manner stated	d				e number					fonth, Day, Year)
ZCY		11.	11 Kie	/ TA.		2	O.C.	M.E.	OGME		August	22, 200	9
7+1		30. Name and address of person wh		death (Item 23a Medical Exa		111 0	ann St	reet Ra	ltimore	e, MD 212	201		
, h		Theodore M. King, Jr., N		rar's Signature				Da		-, 212			
Si Pagis	tate	ST. Date med (MONO) & B	LUUS Leve	un d.	1	all	,						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ Medical Examiner **Funeral** Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director Baltimore, Maryland 21215-0036

	1. Decedent's Name (First, Middle, Las	it)						2. Date of De		Long and	Voor	3. Time of	Déath
n/ :al	Thelma R. Blackwell August 12, 2009									19 <sup>ar</sup>	4:47A	М	
er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1621 Millstone Drive 4c. County of Edgewater										Death ne Arundel		
			Marine to Atabah		er 1 Year		r 24 Hrs.	8. Date of Bi	-t-			lace (State or	
	5. Social Security Number 6. Social Security Number 6. Social Security Number 1	<sup>ex</sup> □м 2 <b>X</b> ] <b>г</b>	e (In yrs. last birtho Y	may) Months		Hours	Min.	12/3/			Vew .	try) Y ork	roreign
	Usual Residence of Decedent							12/5/	1750	, , i.			
호	10a. State 10b. County		10c. City, Town	or Location							1	0d. Inside Cit	-
iec	Maryland Anne Ar	undel	Edgewa	ter								1 🗌 Yes	2 🛛 No
Funeral Director	10e. Street and Number				ip Code				10g. C	Citizen of WI USA		ntry?	
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교	11. Marital Status	12, Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣	ever in U.S.	13. Was Dec	edent of H ecify Cuba	ispanic Or ın, Mexica	rigin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)			Race - American Indian, Black, White, etc.		
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Completed by	15. Decedent's E	ducation	16a. [	L Decedent's Us	ual Occup	ation	-		16b.	Kind of Bus	siness Inc	dustry	
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To Be	17. Father's Name (First, Middle, Last) George Charl	les Olm				_	ner's Nam othy	e (First, Middle Murph		n Surname)			
╚													
	19a. Informant's Name/Relationship (Type, Print)  Otho L. Blackwell/Husband  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 1621 Millstone Drive, Edgewater, MD. 2												
	20a. Method of Disposition	-7114004114	20b. Place of I	Disposition (N	ame of	- 1		Date		Location - 0			
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	21. Signature of Europe Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home												
	<b>►</b> ////////			2973	So1or	nons	Isla:	nd Rd.	Edge	ewater	,MD	. 2103	7
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Bet	
	Immediate Cause (Final disease or condition  Deripheral Vascular disease											Onset and I	
	Immediate Cause (Final disease or condition resulting in death)  Derrheral Vascular disease  Due to (or as a consequence of):  Neguentially list conditions,  b.										1		
ē	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):												
Ē	cause, Enter Underlying Cause (Disease or linjury												
Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence of	):	-						1		
ical	L	d											
Med	IF FEMALE:			_									
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 Fetal death	3 🔲 Ectopi	c pregnan	су				23d. Date Mon			⁄ear
ysic	1  Yes 2 1 No 9 Unknown	4 ∐ Pregnant a 9 ☐ Unknown	t time of death	5 ☐ Other	(specify) _					IVIOII		Day	TCUI
, Ph	Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlyin	g cause gi	ven in Par	t I.	23e. Did	tobacco	use contril	bute to t	he cause of d	eath?
d b	Chronic ob	structiv	e pu	lmon	ary	d	Sea	S 15	Yes	2 □ No :	3 🗌 Pro	bably 4 🗆	Unknown
lete			•		- 1			24a. Wa:				psy findings a	
autopsy prior to completion of death?									·	ause of			
25. Was case referred to medical examiner? 1 Yes 2 N No 1 Yes  26. Place of Death (Check only one)  Hospital: 1 No Other: 4 Nursing Home 5 N Residence 6 Other (Specify)													
								(Specify	()				
	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of inju (Month, Day	ıry 28b. Ti y, Year) in	me of jury	28c. Injui wor	Ŕ?	_	28d. Describe	how inj	ury occurre	d		
ific	2 Accident Investigatio 3 Suicide 6 Could not be	na ————	A 1 1 2	M		Yes 2	⊔ No	ORE L	(Ot)			I Davite Month	
Cerl	4 Homicide determined		ury - At home, fari c. <i>(Specify)</i>	m, street, fact	ory, office			28f. Location City or To			or Hura	ı noute Numb	oer,
Medical Certificate:	29a. Certifier 1 X Certifying Phy	sician: To the best of	my knowledge, d	leath occured	at the time	e, date and	d place, a	nd due to the o	ause(s)	and manne	r as state	ed.	
ed	(Check 2 Medical Exam	niner: On the basis of e	examination and/or	investigation,	in my opini	on, death	occurred a	at the time, date	and pla	ce, and due	to the ca	iuse(s) and ma	nner stated

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed yithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 LD

9 ∐ Unknowń	3 LI CIIKIOWII					
	contributing to death but not resulting in the	ne underlying cause given in Part I.  Manay Ulseas	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown			
		1	24a. Was an autopsy performed? 1 □ Yes 2 1 No    24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical		nly one)				
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA Other: 4 Nursing Home	e 5 🕅 Residence 6 🗆 Other (Specify)			
27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident Investigatio			d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not le 4 ☐ Homicide determined		street, factory, office 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
(Check 2 Medical Exam	niner: On the basis of examination and/or in	ath occured at the time, date and place, and ovestigation, in my opinion, death occurred at the ge, death occurred at the time, date and place,	due to the cause(s) and manner as stated. le time, date and place, and due to the cause(s) and manner stated. and due to the cause(s) and manner as stated.			

29c. License number

MAS, 31 Robinson Road, Severna Park, Maryland 21146

045297

29d. Date signed (Month, Day, Year)

12,2009

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day Y

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arata

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. (\_ 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 17, 8:03P M Bradshaw 2009 August Diane /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cheverly Prince Georges Hospital Prince Georges If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🛛 F 578-56-0785 66 July 19,1943 Wash.,DC Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expropries rust be notified at 1 XYes 2 No Director Temple Hills PG MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with United States 20748 2803 Bellbrook Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: 2 3 X Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 ih and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Goodwill Cashier 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gardner Bradshaw Mozella Willie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2803 Bellbrook Street Temple Hills, Md. 20748 Department of Health ar Important: If Item 27 Is any injury or other trau Mozella Bradshaw/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/24/09 20a. Method of Disposition Pages 1 □ Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sign up of Funeral Service Licensee Suitland, Md. 20746 3910 Silver Hill Rd., 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** minuko disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Diffuse attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 □Yes 2 ☑No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, failerse Drabetes millitus 2 No 3 Probably 4 Unknown 1 🗌 Yes cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? devil Neukir 24a. Was an performe 2 No Concernma certificate torcast 1 ☐Yes 2 No 1 ☐ Yes Physician: : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th pletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D24720

State Registrar 31. Date filed (Month, Day, Year)

**AUG 28** 

ANDONER ROAD CHEVERLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAVINDER K.

			State of Maryland / Department of H  State of Maryland / Department of H  Certificate of L		lental Hygie Reg.	6 6 1 6	07610	
			Decedent's Name (First, Middle, Last)		2. Date of Death	Lance - a second	3. Time of Death	
,	Physicia /Medic	al	NORMA LOUISE BORTAS		AUGUST	<sup>D</sup> ¶ <sup>y</sup> 5 2009	9:02p M	
	Examin	er		Location of Death		4c. County of Death Kent		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birthp	lace (State or Foreign try) land	
	Director		127-24-4761 1 M 2 M F 76 Yrs. World's 283 F 76 Vrs.		Jan 20	1933 Mar	yrand	
	anyland show	_	10a. State         10b. County         10c. City, Town or Location           MD         Kent         Chestertown			1	0d. Inside City Limits 1 XYes 2 No	
	the Ma 28a-f	Director	10e. Street and Number 10f. Zip Code		10g.	. Citizen of What Coun		
	th with 23a or	al Di	107 Rolling Rd. 21620	) .	τ	J.S.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Martical Examination to notified all once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e Specify: Wh		
21215-0036	72 hoi "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupe (Give kind of work done of life. DO NOT use retired)	ation during most of work	ing 16t	Metal	dustry	
2121	l within giene. r than	omo	Elementary/Secondary (0-12) 12  College (1-4or 5+) Quality Con			Manufac	turer	
pu	be filed tral Hyg d othe event,	Be	17. Father's Name (First, Middle, Last) Thomas Cornwell		<sub>e (First, Middle, Mai</sub> et Louis			
Maryland	should nd Mer marke imatic	၉	19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a				Code)	
, <b>Z</b> a	and 2 sealth ar		Janice Prescott (daughter) 13145 Tor			dge, VA.		
Baltimore,	Pages 1 ment of Hi ant; If iter		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemelery, crematory or other place)  Kent Cremation	8/2	2/09 8	Smyrna, D		
Ball	Departition Depart	j	21. Signaluro of Fureral Service Licenses M00510 22. Name and Address Galena F 118 West				L Schaech 21635	
40	Physician / /Medical	5 (	23a. Part T. Enter the disease, or complications that caused the death. Do not entry the mode of dyin shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ng, such as cardiac	1		Approximate Interval Between Onset and Death	
	rificate be executed as physician and as the burial-transit	cal Examiner	b. Due to (or as a consequence of):  any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):		<u> </u>			
.O. Box 68	ath cel	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	;y	23d. Date of delivery Month Day Year			
rds, P.	quires that the de in signed by the a uld be detached f	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tobac	. Was an autopsy prior to completion of cause of death?		
Division of Vital Records,	ysician; The law requir is certificate has been s director, page 2 should	Completed			performe			
Z.	iysiclar is certif director	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	or:	th (Check only one ome 5 Residence	ce 6 ☐ Other (Speci	fv)	
ion of	nding Phy ath. r: After thi e funeral (	ation: T	27. Manner of De In 28a. Date of Injury 28b. Time of Injury Worl	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work?				
Divis	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,	
	Hospit 24 hour Funera tely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the tit (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	me, date and place opinion, death occu	e, and due to the cau irred at the time, date	use(s) and manner as e and place, and due t	stated. o the cause(s)	
	To the within 2 To the Comple	Med	29b. Signature and title of certifier 29c. Licens	se number	290	I. Date signed (Month,	Day, Year)	
			6. age So Jain com D16	400		8-18-	09	
			30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)  Wayne D. Benjamin, M.D. 6602 Church	הם וויּם	Charta	rtorn M	D 21620	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Rigistrar's Signature	TITTT KO	. CHESCE	T. C. QWII P M	V. 21020	

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Ye ar August Kenneth Eugene COE Sr. 2009 16 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Days 1**⊠** M 2□ F 5, 214-46-5304 63 1946 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 XNo Williamsport Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 16060 Spielman Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 TayYes 2 □ No If Yes, Give Year or Dates: 1966-67 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) leather tanning laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Archie Belle Lapole Edgar William Coe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16060 Spielman Rd., Williamsport, Md. 21795 Evelyn Coe - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/18/09 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility 21. Signature of Funeral Service License MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. day Immediate Cause (Final ANOXIC ENCEPHALOPATHY disease or condition resulting in death) MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EMBOLISM ULMONARY Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊞No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

the death certificate be executed and O. Box 68760 0 Division of Vital Records, certificate Physician: After this ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t

ng physician ar signed by the attending I cate has been si page 2 should b funeral filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Maxical Examinar must be notified at

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

Jes 1 and 2 st it of Health at t: If item 27 if

permit. Pages 1
Department of H
Important: If itel
any Injury or oth

Physician

/Medical

Examiner

Pages 1

Funeral Director

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

WH-8+

within 2

CHOTANI HABIB

and manner stated.

MD

29c. License number D58853

₩ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 8/18

HAGERSTOWN, MD21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E ANTIETAM ST. 251

31. Date filed (Month, Day, Year)

**AUG 18** 



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U 55-	UUUZZ	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

		ey Sta For State		Ce	rtificate of	Death		tai Hygier	Reg. No	40	
Di cicio	Re	gistrar Decedent's Name (First, Middle	e,Last)					2. Date	e of Death	Year	3. Time of Death 2151 hrs
Physiciai Iedical Examin	-	PHILIP GORDON CONNOLLEY  4b. City, Town, or Location of Death						Aug	oth Day Just 20, 200	09 c. County of Dea	
		4a. Facility Name (if not institution, give street and number)						of Death		Queen Anne	
		246 Sassafras Road				Millingto		er 24Hrs. 8. D	ate of Birth (MN	M/DD/YYYY) 9. E	Birthplace (State or Foreig
Funeral Director		Social Security Number 214–66–7672	6. Sex	7. Age (In yrs. 53	last birthday) Yrs	Months	Days Hour		EC. 1 1		Maryland
	l	sual Residence of Decedent		Jana Cib	y, Town or Locat	tion					10d. Inside City Limits
v any	1	0a. State 10b. County  MD Oue	en Anne'	1	illingto						1 X Yes 2 No
land f shov	ō_		SII AIIIC			10f. Zip C	ode		10g. C	citizen of What C	ountry?
Mary r 28a- ed at	Director	De. Street and Number  246 Sassafr	25 St				1651		U.	S.A.	
vith the Masyland s 23a or 28a-f show s poiffied at once.				Decedent Ever in	U.S. 13. W	as Decedent	of Hispanic Or	igin? ( Specify	Yes or No-		nerican Indian, Black,
tems	Funeral	Marital Status     Never Married 2 N	Married Arme	ed Forces?	lf `	Yes, specify	Cuban, Mexica	n, Puerto Rican	, etc.)	White, etc	White
er de		3 Widowed 4 XDi	vorced of Yes, Give				No specif			Specify:	
irs aft	<u>\$</u>	15. Decedent's Education (Spe	ecify only highest	t grade completed)	16a. Decede	ent's Usual O	ccupation (Given ng life. DO NO	e kind of work d T use retired)	one 16t	o. Kind of Busine	ss/Industry
72 hou	etec	Elementary/Secondary (0-12	) Colle	ge (1-4 or 5+)			/Elect			Nursing	Home
036 ithin in than	Completed	12			Marine	enance	148 Moth	er's Name (Firs	t. Middle, Maid	_	
5-0 iled w Hygic 1 othe		17. Father's Name (First, Middle Philip Gord	e, Last) Ion Too (	Connolley	7		Bl	anche D	eloris	Thompso	on .
21215-0036 Juld be filed within 7 Mental Hygiene marked other than ic event, the Medica	a	19a. Informant's Name/Relation			19b. Maili	ng Address		umber or Rural	Route Number	, City or Town, S	
D 2 should and M 7 is m	٩	Patricia Su		(sister)			nch Rd.		n, MD.	21678	
and 2 ealth 3 tem 2 traum	-	20a. Method of Disposition			b. Place of Dispo crematory or o	osition (Name	e of cemetery,	Dai		oc. Location - Cit	
Ore	1	1 XBurial 2 Crematic		oval from State	hester	Cemete	ery	8/28/	'09   (	Chestert	cown, MD.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5 Other 21 of Ineral Park	Specify:		22	Name and	Address of Fac	Ty Home	of Ste	phen L.	Schaech
Bal perm Depa Impo		/ // / //	.)/	M0051	10 14	10 100	at Cros	c St C	la Lena .	MD. 216	Approximate Inter
Physician	$\dashv$	3a. Part I. Enter the disease,	or complications	that caused the de	ath. Do not ente	r the mode o	dying, such a	s cardiac or res	piratory arrest,	shock, or neart	Between Onset a
'Medical		failure. List only one cause Immediate Cause (Final disease	I is an order	ensive Atheros	sclerotic Car	diovascul	ar Disease				Death
aminer		or condition resulting in death)	Due to (c	or as a consequenc	e of):						
		Sequentially list conditions,	b. Due to (c	or as a consequenc	e of):						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	se c.								
ii ii	xan	(Disease or injury that initiated events resulting in death) Las	Due to (c	or as a consequenc	e of):						
executed an and al - transit	a l		d	IDED.							
be be uri	edical	UNPENDED								23d. Date of de	elivery
Ox 68760, tath certificate be exattending physician for use as the burial for use	ian/Me	IF FEMALE: 23b. Was decedent pregnant in	the contract of the contract o	If yes, outcome of p Live birth	2	Fetal death	3 Ect	opic pregnancy		Month	Day Year
Box 6876  death certificate the attending phy ed for use as the be	sicial	past 12 months?	4	Pregnant at time of	of death 5	Other (Spe	cify)				
BO; e deatl the att	Phys	1 Yes 2 No 9		Unknown uting to death but r	at reculting in th	ne underlying	cause given i	n Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
s, P.O. Be ires that the de signed by the d be detached f		Part II. Other significant con			of resulting in a	ne andenymis	oucos giriani		1 Yes	2 No 3	Probably 4 Unknow
S, P uires t n sign Id be c	Completed by	Chronic alcohol ab	use, liver uis	ease					24a. Was ar		ere autopsy findings avail
	활								autopsy perform	ned? de	or to completion of cause ath?  Yes 2 No.
ord w req ss bee	ΙE								1 ✓ Yes 2	No 1	Yes 2 No
Records, The law requir ate has been s age 2 should 1	] 5		looi				26.Place of De	eath (Check onl		Residence 6	Other: Scene
al Record an: The law req ertificate has bee	S S S	25. Was case referred to med							ionic o		
Vital Record hysician: The law req this certificate has been director, page 2 should director, page 2 should have a should be	e Be	examiner?	Hospital:	I Inpationt .					d. Describe ho	ow injury occurre	d
of Vital Recording Physician: The law red After this certificate has bee funeral director, page 2 should be submitted the control of the cont	To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital:	1 Inpatient 2 a. Date of Injury (Month, Day,Year)	ER/Outpat 28b. Time		28c. Injury at \		d. Describe ho	ow injury occurre	d
ion of Vital Record trending Physician: The law req feath. tor: After this certificate has bee vy the funeral director, page 2 shou	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 F	Hospital:	a. Date of Injury (Month, Day,Year)	28b. Time	of Injury	28c. Injury at \	Nork? 28	3f. Location (S	treet and Numbe	
ivision of Vital Record or Attending Physician: The law required refer detail. Director: After this certificate has been in the theory, the funeral director, page 2 should in by the funeral director, page 2 should be the property of the funeral director, page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 2 should be the page 3	To Be	examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 ✓ Natural 5 F  2 Accident  3 Suicide 6 0	Pending nvestigation Could not be	a. Date of Injury (Month, Day, Year)	28b. Time	of Injury	28c. Injury at \	Nork? 28		treet and Numbe	
Division of Vital Records, sspital or Attending Physician: The law require hours after death.  In a prector: After this certificate has been so well edin by the funeral director, page 2 should to writted in by the funeral director, page 2 should to	Certification: To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 F 2 Accident 3 Suicide 6 ( 4 Homicide	Pending nvestigation Could not be determined (\$286)	a. Date of Injury (Month, Day,Year) Be. Place of Injury -	28b. Time	of Injury	28c. Injury at \ 1 Yes	Nork? 28 2 No 28 19, etc. 28	Bf. Location (Si or Town, St	treet and Number ate)	r or Rural Route Number,
Division of Vital Record he Hospital or Attending Physician: The law req in 24 hours after death. he Funeral Director: After this certificate has bee	Certification: To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 F 2 Accident 3 Suicide 6 ( 4 Homicide	Pending nvestigation Could not be determined (\$\frac{28}{5}\$  Ig Physician: To Examiner: On the	a. Date of Injury (Month, Day, Year)  Be. Place of Injury - Specify)  the best of my known the best of my known the best of examinate the same that the best of examinate the best of examinate the best of examinate the best of examinate the best of examinate the best of examinate the best of examinate the best of the	28b. Time	of Injury	28c. Injury at \ 1 Yes	Nork? 28 2 No 28 19, etc. 28	Bf. Location (Si or Town, St	treet and Number ate) e(s) and manner and place, and du	r or Rural Route Number, as stated. ue to the cause(s)
Division of Vital Records, P.O. Box 6876C  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic mompletely filled in by the funeral director, page 2 should be detached for use as the b	Certification: To Be	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 F  2 Accident  3 Suicide 6 ( 4 Homicide  29a. Certifier 1 Certifyin (Check only one)  2  Medical	Pending nvestigation Could not be determined (September 20) to Examiner: On the and merical control of the september 20) to Examiner: On the and merical control of the september 20) to Examiner: On the septembe	a. Date of Injury (Month, Day, Year)  Be. Place of Injury - Specify)	28b. Time	street, factor	28c. Injury at \ 1 Yes	Nork? 28 2 No 19, etc. 28 and place, and duth occurred at the	Bf. Location (Si or Town, St	treet and Number ate) e(s) and manner and place, and du 29d. Date signe	as stated. ue to the cause(s)  and (Month, Day, Year)
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			State	aryland / Depa	artment of F rtificate of			000	10	07610	
			Registra MEND#20bperFH, 8-17-09, BMW     Decedent's Name (First, Middle, Last)	Mary Cel	lineate or	Dealii	2. Date of Deat	eg. No.		3. Time of Death	
	Physici /Medic		Warren P. Dettm			August	13, 2009	Year 9	11:32 aM		
	Examin	er	4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County o	f Death			
4	Funeral			e (În yrs. last birthday)	Rockv If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		gomes 9. Birthpla	ce (State or Foreign	
	Director		578-09-8407 1 <sup>™</sup> M 2□F	88 Yrs.	Months Days	Hours Min.	Oct. 9,	1920	Country Wash	ington, DC	
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation				100	d. Inside City Limits	
	a-f sh	ctor	Maryland Montgomery	Kensi	ngton					1 □Yes 2 No	
	vith the	Directo	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wh	nat Country	y?	
	ns 23g	Funeral	4418 Clearbrook Lane  11. Marital Status 12. Was Decedent B	Everin IIS 13 V	20895	lispanic Origin? (Sp	ecify Ves or No-	USA 14 Baco	- Americar	Indian	
5-0036	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or Items 23a or 28a-f show event, the Modical Examirer must be rediffed at	Ď	Armed Forces?  1 Never Married 2 Married  1 Married 1 Ma	lo	fYes, specify Cuba I∐Yes 2⊠No	Specify:	Rican, etc.)	Black	White, etc	D.	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup	ation during most of worki	ina I	16b. Kind of Bus			
2121	filed within Hygiene, yther than '	Completed	Elementary/Secondary (0-12) College (1-4or 5	life [	DO NOT use retired Engineer	d)		Teleph	one (	Company	
מ	al Hygi other	Be C	17. Father's Name (First, Middle, Last)		2.192.1002	18. Mother's Name	(First, Middle, I			company	
ylar	should be tand Mental s marked o	70 E	Arthur Dettmers			Josephi	ne E. Ja	amison			
, Maryland	ges 1 and 2 should I nt of Health and Men if item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Rita V. Dettmers/Wife	19b. Mailin 4418	g Address <i>(Street</i> Clearbro	and Number or Run ok Lane,	al Route Number Kensing	r, City or Town, S ton, MD	tate, Zip C 20895	Code) 5	
altimore,	Pages 1 nent of H ant: If iten ary or oth		20a. Method of Disposition  11 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem Gate of H	sition (Name of natory or other place leaven Ce	Aug. Aug. metery 2	<del>pt.</del> 17	20c. Location - C	-	n, State	
Balt	permit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licensee	Fr 50	Name and Addre cancis J. O Univer	ss of Facility Collins sity Blvd	Funeral	Home In	c. ring,	MD 20901	
ı			23a. Part I Enter the disease, or complications that caused shock, or lieart failure. List only one cause on each lin	the death. Do not ente					4	Approximate nterval Between	
1	Physician /Medical	ner	Immediate Cause (Final disease or condition resulting in death)  Dehydr							Onset and Death	
	Examiner		Due to (or as a	a consequence of):	Disease						
	p ±		Sequentially list conditions,	a consequence of):	DIBCUBC						
)	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					·			
58760,	ficate be executed physician and s the burial-transit		Due to (or as a	a consequence of):							
_	rtificate ng phy as the	ledical	d		117.4%						
O. Box	he death certific the aftending p	Physician/M	in the past 12 months?	s decedent pregnant he past 12 months?  Yes 2 \[ \] No  23c. If yes, outcome of pregnancy 1 \[ \] Live birth 2 \[ \] Fetal death 3 \[ \] Ectopic pregnancy 4 \[ \] Pregnant at time of death 5 \[ \] Other (specify)					23d. Date of delivery  Month Day Yea		
ت. ت	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but	it not resulting in the un	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contrit	oute to the	cause of death?	
Suds	equires en sign ould be	ed by	Dementia				1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown				
ပ္မ	sician: The law re certificate has be rector, page 2 sho	Completed					24a. Was a autops	sy pr med? de	ior to comp ath?	sy findings available pletion of cause of	
/Ita	Physician: rthis certifica ral director, p	BeC	25. Was case referred to medical examiner?			26. Place of Death		e)	∐Yes 2		
=	his di	<u>1</u>	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie  27. Manner of Death 28a. Date of Injur	nt 2 ER/Outpatien		4 LI Nursing Ho		ence 6 🖾 Other	(Specify)	ed Living	
0	nding Phy tth. :: After thi e funeral c	ation	11 Natural 5 Pending (Month, Da) 2 Accident investigation	(, Year)	Worl	yat k? Yes 2 □No	28a. Describe no	ow injury occurred	9		
DIVISION	To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After to completely filled in by the funera	Certification:	a Deviate 6 Devild not be	iry · At home, farm, stre :. (Specify)	eet, factory, office		28f. Location (St City or Town	treet and Number n, State)	r or Rural I	Route Number,	
	ne Hospitu n 24 hours ne Funera pletely fille	edical (	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of and manner sta	examination and/or inv	n occurred at the til vestigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and mar late and place, ar	ner as sta nd due to t	ited. he cause(s)	
	Vithin To the comp	Me	29b. Signature and title of certifier		29c. Licens			9d. Date signed	(Month, Da	ay, Year)	
	1547		Resecce MJown	1	1000	16032		8113	10	9	
			30. Name and address of person who completed cause of de Rebecca Musher Gross, MD	10400 Conn	Print) ecticut A	Avenue, K	ensingto	on, MD 2	0895		
	Sta Registr		AUG 14 2009 Server	ar's Signature	10						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 13, 2009 **Physician** ам 11:10 Robert John Evans /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arcola Health & Rehab. Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, **Funeral** Days Hours 1₫M 2□ F 220-38-4850 Feb. 8, 1940 Washington, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 220 Whitmoor Terrace 20901 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 No lf Yes, Give 1959-62 Year or Dates: 1 ☐ Never Married 2 ☐ Married 0. Specify: White 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced natura!" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Item Once. Camera Operator Self-Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Randall Evans Gene Marie Vana ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria E. Hussein/Sister 10313 Conover Drive, Silver Spring, MD 20902 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20a. Method of Disposition
1 □ Burial 2 🖰 Cremation 3 □ Removal from State Date Aug. 13 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Sign fur of Funeral Service Linense 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Melanoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e. Further this certificate has been signed by the attending physician and e Funeral Director: After this certificate has been signed by the attending physician and leiely filled in by the furnaral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ∐Yes 2 ∐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown **Emphysema** Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 K No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**X**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00064624

State Registrar

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

10901 Connecticut Avenue, Kensington, MD 20895

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Sign

Sandeep Sharma, MD

AUG 14

31. Date filed (Month, Day, Year)

August 13, 2009

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 11, Day 2009 ear Physician/ 4:10 A M Frances H. Errico Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months 1 1 - 1 4 - 1 9 1 7 North Carolina 91 Director 578-16-2321 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 💆 No Maryland Anne Arundel Churchton 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 23a Funeral USA 20733 1246 Chesapeake Dr. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify. 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Library of Congress 12th  ${\tt Clerk}$ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earnest Holt McFarland Alice Hester Petty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1246 Chesapeake Dr., Churchton, MD 20733 Alyce E. Scott/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 8/14/09 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) und a Pervice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Por as a consequence of): disease or condition resulting in death) ears Medical Due **Examiner** ears heime Some tiely list reaching if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed (Natitin 24 hours after death.)

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director. arkinsons that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Yes 2 No ER/Outpatient 3 DOA ည 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? Natural 5 Pending 2 🗆 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane Suite 222 Bowie MD20715 31. Date filed (Month, Day, Year State Registrar

Hospital or Attending Physician: The law requires that the death certificate be executed Records. of Vital Division within 24 hours a To the Funeral L

29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS KAUFMAN, M.D. 12070 OLD LINE CENTRE #207 WALDORF, MD 20602 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be

determined

3 Suicide

29a, Certifier (Check only one)

4 Homicide

Registrar DHMH 17 Rev 1/2001

State

filled in I

State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar	and / Department of He  Certificate of De	-	Reg. No. 2009	2764 3. Time of Death			
Physician /Medical	Decedent's Name (First, Middle, Last)     Herbert Frieds	man	Month	Day Year <b>13, 2009</b>	5:04 a <sub>N</sub>			
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death					
	Suburban Hospital		thesda		gomery			
Funeral Director	169-26-3802 1≅M 2□F 7	Months Days	f Under 24 Hrs. Hours Min.  8. Date of Bi (Month, Di March	ay, rear)	thplace (State or Forei ountry) nsylvania			
72 hours after death with the Maryland 'naturals', or items 23a or 28a-f show or it is similar must be notified at eted by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c.	City, Town or Location			10d. Inside City Limi			
Mar a-f s ffied	Maryland Montgomery	Chev	y Chase		1 ☐ Yes 2 🗷 N			
ith the Mary or 28a-f st be notified Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?			
3a o	5511 Friendship Blvd., #611		20815	U	.S.A.			
permit. rages I and 2 should be most which it is found a diet beautivitin the manyar Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Marital Status  1 Married   12. Was Decedent Ever in Armed Forces?  1 Yes 2 Married   1 Yes 2 (Married Forces)	n U.S. 13. Was Decedent of Hisp if Yes, specify Cuban,	panic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	o- 14. Race - Ame Black, Whit	e, etc.			
ical Ex	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupati (Give kind of work done dur	on	16b. Kind of Business	Caucasian /Industry			
yylene. her than "natura t, the Medical E	Elementary/Secondary (0-12)  College (1-4or 5+)  5+	life. DO NOT use retired)  Researche:		Chemi	istrv			
d other event, it Be Co	17. Father's Name (First, Middle, Last)		8. Mother's Name (First, Middle					
arked atic ev	Benjamin Friedman		Jenni	e Bremmler				
marl marl	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and	d Number or Rural Route Numl	per, City or Town, State,	Zip Code)			
trau	Larry Friedman - Nephew		d, Pittsburgh, Pen					
ther		b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or				
tant: If it jury or o	1 <b>3</b> Burial 2 ☐ Cremation 3 ☐ Hemoval from State 4 ☐ Donation 5 ☐ Other (Specify)	Jewish Holy Cemetery	08/14/2009	Hopwood, Pen	nsylvania			
Impor any in	21. Signature of Funeral Service Licensee		Funeral Home, Incoshire Avenue, Sil					
/sician	23d. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Pneumonia	eath. Do not enter the mode of dying,	such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death			
edical miner	Due to (or as a consequence of):							
in the	Sequentially list conditions, if any, leading to immediate course. Enter Uncertains	sequence of):						
nsit nin	Cause (Disease or injury							
g physician and as the burial-transit	that initiated events c Due to (or as a constitution of the	sequence of):						
or use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year			
be d	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given		tobacco use contribute t				
cate has been s page 2 should Completed			per	opsy prior to formed? death?	utopsy findings avail completion of cause s 2 \(\sigma\) No			
ertifica ector, p	25. Was case referred to medical examiner?	2	26. Place of Death (Check only	one)				
this ce		2 ☐ ER/Outpatient 3 ☐ DOA Other:	4 ☐ Nursing Home 5 ☐ Res	sidence 6 Other (Sp	ecify)			
After funera	27. Manner of Death  1 12 Natural 2 Accident 3 Suicide 6 Could not be  28a. Date of Injury (Month, Day, Year	M 1 ☐ Ye	es 2 🗆 No	how injury occurred				
	4 Homicide determined 200. Place of injury - A building, etc. (Sp		City or To	(Street and Number or F own, State)				
orthin 24 hours a public at the Funeral Completely filled	29a. Certifler (Check only one)  1 ★ Certifying Physician: To the best of my 2 ★ Medical Examiner: On the basis of examond manner stated.	nination and/or investigation, in my opi	nion, death occurred at the time	e, date and place, and du	ue to the cause(s)			
D Substitution of the subs	29b. Signature and the obcertifier	29c. License i	2949	29d. Date signed (Mor 8/13/09	nth, Day, Year)			
	30. Name and address of person who completed cause of death ( Natasha Prtina Haag, M.D., 8600 O	ld Georgetown Road, Be	thesda, Maryland 2	20814				
State Registrar	31. Date filed (Month, Day, Year)  AUG 14 2009  32 Registrar's Si	A. Sall						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Day Year **Physician** Eddie Freedman August 11, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 19 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1XX M 2 1 F Director 459-18-8011 88 1921 Texas Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov Director 1KIYes 2 □ No Montgomery Silver Spring with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Finsbury Park Court 20906 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status e filed within 72 hours after dal Hygiene.

other than "natural", or iten Black, White, etc. Affiled Forces: 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn important; if Item 27 is marked other the apprehence of the control of the Owner Trash Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Freedman Mary Aronson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye A. Freedman, wife 20906 14 Finsbury Park Court, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 🔀 Removal from State King David Memorial 08/13/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signati e of Fu er 15. rvice Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. MO1255 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a Upper Gastrointestinal Bleed disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Acute Renal Failure Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events be executed burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Cher (specify) the a 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform certificate 1 Tyes 2X No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after dea...ral Director: Aftr 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067782 AUGUST 11 2009

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Jawad Arshad, MD, 9901 Medical Center Drive, Rockville, Maryland

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 14 2009

		For State Registrar		of Maryland		rtificate of			Reg. No.	nnn	0761
		1. Decedent's Name (First, Midd	le, Last)					2. Date of De		V	3. Time of Death
Physici			Bessie	R. Flaxma	n			Month August	Day <b>12</b>	Year <b>2009</b>	6:00 aM
/Medie		4a. Facility Name (If not institution			-	4b. City, Town, c	r Location of D			ty of Death	1
Examir	ner	Landow			1	10. 013, 10111,	Rockvil1			Montgo	merv
	ó.	5. Social Security Number	6. Sex	7. Age (In yrs. I	act hirthday)	If Under 1 Year	If Under 24		th.		lace (State or Foreig
Funeral			1 □ M 2 K F		Vrc	Months Days		Min. (Month, Da	ay, Year)	Coun	ntry)
Director		041-10-5625		97				November	16, 191	L COII	necticut
pu *		Usual Residence of Decedent  10a. State 10b. County	1	10c City	y, Town or Lo	cation				1	0d. Inside City Limit
filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, tha Pudical Exp. Jirut must be Lettlind	=	Tou. Oldic		100.0.5	, , , , , , , , , , , , , , , , , , , ,						1 ☐ Yes 2 🗷 N
e Marf	5	Maryland Mo	ntgomery				Rockville				
£ 75	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Cour	ntry?
h wi		1799 East J	efferson St	reet			20852			U.S.A	•
deat ms	Funeral	11. Marital Status		cedent Ever in U.S	S. 13. 1	Was Decedent of I	lispanic Origin	? (Specify Yes or No uerto Rican, etc.)	o- 14. R	ace - Americ	
fer fer		1 ☐ Never Married 2 ☐ Ma		2 🕱 No		_		uerto Rican, etc.)		lack, White,	etc.
Irs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, G d Year or I			1 □Yes 2► No	Specify:		Spe	cify:	White
tura Hou	pe	15. Decede	nt's Education			dent's Usual Occu			16b. Kind of	Business/Inc	dustry
n 72	Completed	(Specify only highe	est grade completed,			kind of work done DO NOT use retire		working	Ĭ		
withi	Ē	Elementary/Secondary (0-12)	College	(1-4or 5+)		Bookk	eener			Pharma	cv
Hygi Hygi ther		17. Father's Name (First, Middle	l act)					Name (First, Middle	Maiden Surn		
tal F	Be						To. Monter 5	,			
should be f and Mental I s marked of numatic eve	은	Wi	lliam Danne	nberg					mmerman		
		19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number o	r Rural Route Numb	er, City or Tov	n, State, Zip	Code)
1 and 2 Health tem 27 I		Sandra Winnick	- Daughter		5616	Glenwood :	Road, Bet	hesda, Mary	1and 208	17	
s 1 s of He oth		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	ce)	Date	20c. Locatio	n - City or To	own, State
Pages nent of I ant: If ite ary or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (				natory or other pla ght		08/16/2009	Rownton	Roach	Florida
permit. Page Department of Important: If any injury or once.		21. Signature Funer I Service		Moi	norial G	argens 2. Name and Addre		071072007	Doyncon	beach,	TIOTIGE
Deps mpo Iny i		21. Signatur Funeri Service	The last	1 (/2	- , Н	ines-Rinal	di Funera	1 Home, Inc			
	1	23a. Part 1. Enter the disease, of	V. W.	TUXA	-					ng, mar	yland 20904 Approximate
ficate be executed the physician and the burial-transit to the bur	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hy	pertension o (or as a consequence perlipidem o (or as a consequence or a	uence of):  nia uence of):						
ate b hysic he bi	dical		d. Pe	ripheral A	rtery D	isease					
rtific ng pl as t	Jed	IF FEMALE:					-				
Se Se	Ē	IF FEMALE:	00 1/	utcome of pregna							
ر <u>ه</u> ۲	.10	23b. Was decedent pregnant				Ectonic pregnan	C)/			Date of deliv	
death certific e attending p d for use as	0	in the past 12 months?	1 ☐ Live 4 ☐ Pre	e birth 2 🗆 Feta gnant at time of d	Ideath 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су			Date of deliv	ery Day Year
the death y the atter iched for u	ysic		1 ☐ Live	e birth 2 🗆 Feta gnant at time of d	Ideath 3		су				
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uires that the death is signed by the attend be detached for u	þ	in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown  Part II. Other significant condit	1 □ Live 4 □ Pre 9 □ Unk	e birth 2  Feta gnant at time of d known	Ideath 3 death 5 death	Other (specify)			tobacco use co	Month ontribute to t	Day Year he cause of death?
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ital or Attending Physician: The law requires that the death us after death. ral Director: After this certificate has been signed by the atten lifed in by the funeral director, page 2 should be detached for u	Certification: To Be Completed by	in the past 12 months?  1	al Hospital: 1 28a. Dat (Mo tigation d not be mined 28e. Place	e birth 2 Feta gnant at time of d known  death but not resu  Inpatient 2  e of Injury onth, Day, Year)  ce of Injury - At h ding, etc. (Specif.	ER/Outpatiel  28b. Time o Injury	nt 3 DOA Other (specify) and other (specify) of the determinant of the	26. Place of her: 4 ☐ Nursi	24a. Waaute perl 1	tobacco use colored to tobacco use colored tob	Month  ontribute to t  ontribute to t  ontribute to t  ontribute to t  ontribute to t  prior to codeath?  1 □ Yes  Other (Specificurred	he cause of death?  bably 4 □ Unknow  posy findings availat  impletion of cause of  2 □ No  Assisted  fy) Living  al Route Number,
Hospital or Attending Physician: The law requires that the death 4 hours after death. Funeral Director: After this certificate has been signed by the attentiely filled in by the funeral director, page 2 should be detached for u.	Certification: To Be Completed by	in the past 12 months?  1	al Hospital: 1 28a. Dat (Motigation di not be mined 28e. Placing Physician: To that Examiner: On the	a birth 2 ☐ Feta gnant at time of d known  death but not rest death but not rest death but not rest death but not rest death but not rest death but not rest death but not rest death but not rest death but not rest death but not rest death	ER/Outpatier  28b. Time o Injury  pome, farm, str	nderlying cause gi	26. Place of her: 4 \square Nursi ry at rk?  Yes 2 \square No	24a. War autroper 1	tobacco use colored to tobacco use colored tob	Month  ontribute to to to a superior to codeath? I wes  Other (Special curred)	he cause of death? bably 4 □ Unknow pasy findings availabined of cause of 2 □ No  Assisted fy) Living  al Route Number,
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To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for u	Be Completed by	in the past 12 months?  1	al Hospital: 1 Sea. Dat (Mot ding Physician: To the land mailer.)	e birth 2 Feta gnant at time of d known  death but not result to the control of t	ER/Outpatier  28b. Time o Injury  pome, farm, str	Other (specify)  Int 3 DOA Other (specify)  Int	26. Place of her: 4 \square Nursi ry at rk?  Yes 2 \square No	24a. War autroper 1	tobacco use colored to tobacco use colored tob	Month  ontribute to t  o 3 Prol  b. Were auto prior to co death? 1 Pves  Other (Speci curred  mber or Run  manner as be, and due t	he cause of death? he bably 4 Unknow possy findings availab completion of cause of 2 No  Assisted fy) Living al Route Number, stated. o the cause(s)
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7.1	Physicia	an		rrant						Month	Day		ar	L:30 aM
	/Medic	_	4a. Facility Name (If not institution, gi			4b. City	Town, or	r Location		August		County of D		
	Examin	er	Holy Cross Hospi					princ				ntgom		
	Funeral		5. Social Security Number 6.	Sex 7, Age	e (In yrs. last bir	thday) If Unde	r 1 Year	If Under	24 Hrs.	8. Date of B	Birth	9.1	Birthplace (S	tate or Foreign
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p	>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location							10d Inc	ide City Limits
aryla	shov ad at	5		G 1 -										Yes 2X No
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tter 0	r iter		1 ☐ Never Married 🏂 Married	Armed Forces?	No	13. Was Dece				Rican, etc.)		Black, W		
030 ours	ral", c Exan	b S	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1942-46	1 ☐ Yes	21 <b>25</b> No	Specify:				Specify: W	hite	
5-0	natu	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	16a.	Decedent's Usu (Give kind of we life. DO NOT u	al Occup	ation during mos	st of worki	ng	16b. Ki	nd of Busine	ss/Industry	
Z iffi	han "	du	Elementary/Secondary (0-12)	College (1-4or 5	+)						<u>.</u> .	_	_	
S D	Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Las			istrict	DIL			(First, Middi			Rever	ue Servio
and	ental ced o	o Be	Michael Ferrant	• •						ine Burg		,		
aryl shoul	mari	၉	19a. Informant's Name/Relationship		19b	. Mailing Addres	s (Street a						e, Zip Code)	
Nd 22	alth a 27 is 27 is rrtrau		Nancy Ann Ferra	nt/Wife	31	.42 Grac	efie	ld Ro	ad,	#608,	Silve	r Spr	ing, M	ID 20904
<b>16</b>	Item		20a. Method of Disposition		20b. Place of	Disposition (Nary, crematory or	me of	(a)		Date	20c. Lo	cation - City	or Town, St	ate
mo Page	int: If		1 Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec		I	Branch	-		Au	g. 17, 2009	West	minst	er. MC	)
Baltimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	ensee MAGA		Franci	nd Addres	sscf Facili	ins	Funera				ID 20901
ша	으트 등 의		1 JON JEC	70001		_			-			r Spr		
			23a. Part I. Et ter the dease, or cor shock, or heart failure. List only	nplication What caused y one cause on each lin	the death. Do r	not enter the mo	de of dyin	ig, such as	s cardiac c	or respiratory	arrest,		Interv	ximate al Between and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	Malignan			m							
	aminer		1	Due to (or as	a consequence	of):								
	<b>\$</b> _0	<u>r</u>	Sequentially list conditions, if any leading to immediate	b. Due to (or as	a consequence	of):							-	
Uted D	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		·									
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c 66	ing ph	Med	IF FEMALE:										1	
300 ath ce	attending p	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death			/			100	23d. Date of Month	delivery Day	Year
d/10/23 .O. Box 6	by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 ☐ Other (s	pecify)				.	Month	Day	Tour
P. P.	ed by detac		Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying	cause give	en in Part l	I.	23e. Dio	d tobacco u	se contribut	e to the caus	se of death?
Records, P The law requires that	signed Id be det	d by			•					1 [	] Yes 2	No 3	] Probably	4 <b>₺</b> Unknown
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Be a	page 2 s	m d								aut	topsy rformed?	death	ነ?	dings available n of cause of
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r <	this cer at direc	LoB	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatie	nt 2 HER/Ou	tpatient 3 D	OA Oth	Or.		me 5□Re		6 Other (S	Specify)	
Vision or Vita			27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui	ry 28b. 1	Time of njury	28c. Injur Worl			28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Siol	or Al	atic	2 ☐ Accident investigation	on		М	1 🔲	Yes 2□	No					
	Director	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ıry - At home, fa c. <i>(Specify)</i>	rm, street, facto	ry, office		2	28f. Location City or T	(Street an own, State	d Number oi )	r Rural Route	Number,
pital	Funeral Detection of the February Filled	Ce	29a. Certifier 1 **Certifying P	thusiains. To the best of	of my knowlodge	doath coourse	d at the at							
Div To the Hospital or		edical	(Check only one)	Physician: To the best of miner: On the basis of and manner sta	examination an	d/or investigatio	n, in my o	ne, date al prinion, de	ath occurr	and due to the red at the tim	e, date and	and manne I place, and	r as stated. due to the ca	ause(s)
To th	within 2	Me	29b. Signature and title of certifier	Va	1	29		e number			ł	e signed (M	-	ear)
17.	11		Model	w Klen	West	CAL	D3	36716			Augu	st 12,	2009	
			30. Name and address of person who Andrew Kundrat,			Type, Print) eld Road	đ, Si	lver	Spri	ing, Mi	D 209	04		7
4	Sta Registra	-	31. Date filed (Month, Day, Year) AUG 1 4 20	109 Registra	ar's Signature	pares								

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 26 per DVR 6895 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood 8. Date of Birth (Month Day Year) 04/18/1921 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 □ M 2 🗸 F Months Hours Maryland 213-16-0684 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural" ~-\* any hipty or other traumatic event. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Anne Arundel Annapolis 1 □Yes 21 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 United States 1908 Marconi Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace Hartsock Howard Walter Gerrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9603 Lismore Lane, Estero, Florida 33928 19a. Informant's Name/Relationship (Type. Print) David Haupt/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 09/03/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part t 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? 1 Yes 2 No spital or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number LD

Registrar

State

31. Date filed (Month

Name and address of person who completed Jause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 21, 2009 9:00 August р RALPH KELLY GALLION /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Darlington 3508 Smith Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 22, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) - 1938 **Funeral** Months Days Hours 1 □M 2 □ F Maryland 212-38-1027 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examination uses to modified at 1 ☐ Yes 2X No Darlington Director MD Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21034 3508 Smith Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after Hygiene. 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 □ Yes 🏖 🛣 No Specify: ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sheriff's Dept. Deputy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fili ment of Health and Mental H tant: If item 27 is marked oth Ralph Coast Gallion Anna Mae Lay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3508 Smith Road, Darlington, MD Linda A. Gallion/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any injury or c 🛍 Burial 2 □ Cremation 3 □ Removal from State 8/25/2009 Darlington, MD Dublin So.Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 600 Main Street 21. Signature of Fineral Service Licens 22. Name and Address of Facility 17314 Harkins Funeral Home, Inc. Delta, PA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final month 10 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 221No 1 ☐ Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

DHMH 17 Rev 1/2001

ot

Registrar

29b. Signature and title of certifier

NIVAT

Milip

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dumin

M. D. 32. Registr

602

29c. License number

29d. Date signed (Month, Day, Year)

wood Rd. Suive 200 Bel Air, modIOLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1100 M 9005 40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Subur Bel ban te sva 10000 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) 6. Sex **Funeral** Months Days 1 🔀 M 2 🗆 F CT 01/30/1915 Director 578-09-9436 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ral", or items 23a or 28a-f shov Examiner must be notified at 28a-f shov 1 X Yes 2 ☐ No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20854 13002 North Commons Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 "natural", or Completed by 1 X1Yes 2 □ No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Argentina 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Printer 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Dorman ပ္ Philip Hofberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) p.rmit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai 13002 North Commons Way, Rockville, MD Myra H. Cohen, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Gdns | 08/13/2009 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland 21. Signature of Funeral Service Licensee EDWARD AGGEL FAFUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland 20852 mo1255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examine Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): r() Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 ☐Yes 2 ☐No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{\text{Residence}} \) 6 \( \text{Other} \) (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 | Natural Se// Som chair 1900 1 1 ☐ Yes 2 No 2X Accident 6 ☐ Could not be City or Town, State) 799 E Just ers 2 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minner as stated.

| Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph | Graph 29a, Certifier Medical and manner stated. 29c. License number 062949 29b. Signature 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) ta 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Janice Laraine HAMMOND 2009 3:20 a. M August 18, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Golden Living Center Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 80 Sept. 7, 1928 212-24-6204 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 750 Dual Highway Funeral 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerio Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married white altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ₩ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) department store sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be William David Pettit Zora Burgan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun 177 Scarlet Oak Dr., Martinsburg, WV 25405 Irvin R. Hammond, II - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Greenlawn Mem. Park 8/20/09 Williamsport, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 21740 415 E. Wilson Blvd., Hagerstown, Md. Minn ch 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1CA **Physician** /Medical is a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed 1□ Yes 2□No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete

3H-3 State

31. Date filed (Month, Day, Year) AUG 18

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Registrar

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			1 - For Amend Items 25 tate of Maryland / Der me	partners of Health and Merificate of Death	lental Hygi	iene 0 0 9	27655
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	n Day Year	3. Time of Death
	Physicia		William Ernest Husk		August	15 2009	2:40 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Julia Manor Nursing Home	Hagerstown		Washingt	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Coui	
	Director		255-54-1052		May 27,	1923   West	Virginia
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		1	I Od. Inside City Limits
	danyi f eho	ō	Margaland Washington H	agerstown			1 ☐ Yes 2 🛣 No
	28a-	rect	Maryland Washington Ha	10f. Zip Code	10	0g. Citizen of What Cour	ntry?
	3a or	ā	10016 Melody Lane	21740		USA	4
	me 2	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No-	14. Race - Americ Black, White,	can Indian,
9	or Ite	Ē	1 Never Married 2 Married   Armed Forces?   1 X Yes 2 No 1945   1 Yes, Give	1 ☐ Yes 2 √ No Specify:	rican, etc.)	Specify:	eic.
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or lieme 23a or 28a-f ehow the Mcdical Examiner must be notified at	d b	3 XWidowed 4 □ Divorced Year or Dates: 1947	TE 163 2X 110 Specify.			White
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Maryland	shoute nd Me mark mark	2	William Festus Husk  19a. Informant's Name/Relationship (Type, Print)  19b. Mi	illing Address (Street and Number or Rui			code)
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ē,	r Hee		20a. Method of Disposition 20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City or T	
Baltimore	Pages nent of I ant: if Itu ury or o		1 M Burial 2 Cremation 3 Removal from State	n Memorial Park Aug.	19,2009H	agerstown,	Maryland
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			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between
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	/Medical		resulting in death)  Due to (or as a consequence of):	TZ /- Ilya	1		
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of	Phys this al dir	은	1  Yes 2	tient 3 DOA 4 Trursing n		ence 6 □Other (Spec ow injury occurred	ıfy)
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Ε	after after Dire d in b	Certification:	4 Homicide building, etc. (Specify)  Nursing Home		Hagerst	own, MD	II Street
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier (Check pril) 1 Certifying Physician: To the best of my knowledge, do (Check pril) 2 Medical Examiner: On the basis of examination and/of and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the corred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	Fo thi Within Fo the	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	Dey, Year)
			) le gnuo	200450	31	AUG 16	2009-
24	H 2+1		30. Name and address of person who completed cause of death (Item 23a) (Ty SHAHAD 2 80 BDTQ JJ 32 4 13		Hap 1	MD 21741	0,
Ĭ	Sta	ate	31. Date filed (Month, Day, Year)  32. Registrar's Signature		0		
, K	Regist	rar	AUG 18 2009	Box de V			

DHMH 17 Rev 1/2001

MECAR

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 12 NANNIE HUNTER 2009 8:35AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Southern Maryland Hospital Center Prince George's Clinton 8. Date of Birth (Month, Day, Nov. 5, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) <sup>Y</sup>1918 1 □ M 2 🕱 F Months Days Hours Min. North Carolina Nov. 221-10-7016 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince 1XYes 2 No George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2409 Gaither Street 20748 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify: 3 ₩ Widowed 4 Divorced American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Examiner 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Connie Melton Della Kenda11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5320 Dorsey Hall Dr., #209, Ellicott City, MD 21042 Brenda Powell (Daughter) 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l. Park | 08/19/2009 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or a a consequence of) Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Quence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vos 221No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗍 Inpatient 2 R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Natural 5 Pending

/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760,

certificate

Division of Vital Records,

Hospital or Attending Physician:

**Physician** 

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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Director

Funeral

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

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Department of Important: If it any Injury or o once.

altimore, Maryland 21215-0036

Exami Physician/Medical been signed by the should be detached <u>چ</u> Completed hin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director, Be မ Certification:

Medical

29a. Certifier

**AUG 17** 

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certif

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perstate 6895 vand / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 0943 Mae Elizabeth Hinchey August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster <u>Carroll Hospital Center</u> 8. Date of Birth (Month, Day, Sept 20 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. <sup>Year)</sup>1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ xF MD 220-<del>13</del>-3300 83 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examirat naturation at 1X Yes 2 No Director Carroll Westminster MD the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21157 2 Wimert Avenue Funeral death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XNo Specify: ģ White 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Rebecca Beegle Flais Oliver Ibex ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau Westminster, MD 21157 2 Wimert Avenue Robin Hinchey/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from State 8/18/2009 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem 21. Signature of Funeral Service Licenses Printer of the farithme and Chapel, P.A. alex Westminster, MD 21157 412 Washington Road 23a. Part1. Enter the disease, or complexitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician Devere Michreum disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Devoul F Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed 1 ☐Yes 2 ☐ No 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural
Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 2 WJL 30. Name and address of person also completed cause of death (Ite / 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

			For State Registrar	State o	f Maryla	and / Dep <i>Ce</i>	artmen ertificate					giene Reg. No.	009	27658
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Eugenia Kirk Han								2. Date of Dea Month 8/	ath 9 / 200	9 Year	3. Time of Death 2334 M
	Examin		4a. Facility Name (If not institution, giv Baltimore Washin	e street and nui gton Me	nber) dical	Center			Location urnie				ounty of Dea	
h	Funeral Director		5. Social Security Number 130-09-3797 6. S	ex □ M 2 🛛 F	7. Age (In y	vrs. last birthday 89 Yrs.	) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month Da 10/23	/ 1919	9. Bir	thplace (State or Foreign ountry) NY
	12 should be filed within 72 hours after death with the Maryland and Martal Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, to a herifon Eventing to until a	Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  Anne Aru  10e. Street and Number  915 Crystal Spri  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  (Specify only highest grave Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last, Kenneth Kirk	ng Farm  12. Was Decc Armed Fo 1	g Farm Rd.  12. Was Decedent Ever in U.S. Armed Forces? 1		10f. Zip	dent of Hi cify Cuba Wo al Occupa the done of se retired	Specify ation during mos	rigin? (Spenn, Puerto l	ecify Yes or No Rican, etc.)	14 S	Black, Whit pecify: of Business Educ	erican Indian, e, etc. White
laryla	2 should n and Mer Is marke raumatic	2	19a, Informant's Name/Relationship (	Type. Print)			•	•	and Numb	er or Rura	al Route Numb	er, City or T		•
Baltimore, N	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		John Homme1  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 2)  21. Signature of Funeral Service Licer	y)	State	b. Place of Disp cemetery, cre Atlantic	osition (Namerical National Na	ne of ther plac 1ator Id Addres	e) Sy ss of Facil	8/18/ i <sup>ty</sup> Harc	Glen (2009) lesty Francoli	20c. Loca Glen unera	tion - City or Burni 1 Home	e, MD , P.A.
	Chysician / Medical Examiner the priight-transit the priight-transit characters and the priight-transit characters are considered as a constant of the priight characters are considered as a constant of the priight characters are constant of the priight	dical Examiner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Julio b. Due to	(or as a cons	sequence of): sequence of):	nter the mod	le of dyin	ng, such a	s cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. Box 68	eath certifi attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□ F nant at time	etal death 3	☐ Ectopic p		у			23	d. Date of de Month	elivery Day Year
Records, P.	law requires that the dras been signed by the 2 should be detached	Completed by Ph	Part II. Other significant conditions	contributing to d	eath but not	resulting in the	underlying c	ause giv	en in Part	I.	1 ☐ 24a. Was auto	yes 2 🔀	No 3 ☐ F	to the cause of death?  Probably 4  Unknown  utopsy findings available completion of cause of
Vital R	ilctan: The lav certificate has rector, page 2	Be Con	25. Was case referred to medical						26. Plac	e of Death	perfo 1 □ Yes 1 (Check only o	-	death?	s 2 StNo
Division of V	Attending Phys If death. ector: After this by the funeral di	Certification: To E	examiner?  1 Yes 2 No  27. Manner of Death  1 No Natural 5 Pending investigatio 3 Suicide 6 Could not be determined	28a. Date (Mon	of Injury th, Day, Yea	2 SER/Outpatie 28b. Time Injury At home, farm, s	of 2	28c. Injur Worl	4 🗆 1	]No	me 5 Resi 28d. Describe 28f. Location ( City or To	how injury	occurred	ecify) Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical Ce	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Example	miner: On the b										
	To the within 2 To the comple	Me	29b. Signature and title of certifier	N	10		290	c. Licens	se number	8		29d. Date	signed (Mor	oth, Day, Year)
2	Sta Registr		Du Carl (Month, Day, Fear)	Scolly	se of death (	(Item 23a) (Type	park	gluo	or .	SW	Olis	Bu	mu.	MD 2061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06133 State of Maryland / Department of Health and Mental Hygiene Lawrence Henry 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 6, 2009 0431 hrs **Medical Examiner** Lawrence James Henry 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Talbot 219 South Washington Street If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours Director August 19,195 035-36-0778 Venezuala 1 X M 2 F 57 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show Talbot Easton Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 21601 1175 South Washington Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Armed Forces? 2 X No Yes White Yes, Give Yeer Yes 2 X No specify. Specify: Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 | Baltimore, MD 21215-0036 Unemployed ont of Health and Mental Hygiene.

It: If item 27 is marked other the 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Hutchison John A. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 1175 South Washington Street, Easton, MD 21601 Esther H. Henry/mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Aug. 2009 Chesapeake Cremation 1 Burial 2 X Cremation 3 12 rtant: Stevensville, MD Center Donation 5 Other Specify 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home,
200 South Harrison Street, Easton, MD 21601 21. Signature of Funeral Service Licens e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the dise Physician Between Onset and failure. List only one cause on each line. /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last dical AMENDED 23a,27,perME G894 8/31/09 TT X UNPENDED 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 V Yes No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical

Division of Vital Records, P.O. Box 68760,

examiner?

1 ✓ Yes

27. Manner of Death 1 X Natural

Accident

Suicide Homicide 29a. Certifier 1

29b. Signature and title of certifier

2

3

No

Pending

Investigation

Could not be

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Certification

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical

> State Registrar

Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month, Day, Year, AUG 28 2009

30. Name and address of person who completed cause of death (Item 23a)

Hospital:

Inpatient 2

28a. Date of Injury (Month, Day, Year)

and manner stated.

Registrar's Signature

Other<sub>4</sub>

1 Yes 2 No

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Nursing Home 5

**OCME** 

Residence 6 V Other: Scene

28f. Location (Street and Number or Rural Route Number, City

August 7, 2009

29d, Date signed (Month, Day, Year)

28d. Describe how injury occurred

ER/Outpatient 3

28h Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Day Year AUGUST 2009 15:27 ERNEST M. HOLT 19, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Vea rl Min. 1√2 M 2□ F Months Days Hours MARYLAND 84 Director 220-16-6503 Oct.7,1924 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h Count 10c. City, Town or Location 28a-f show Examiner must be notified at 1 □Yes 2 No Director CRESAPTOWN MD ALLEGANY 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 23a or Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21502 USA 12824 DARROWS AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 Baltimore, Maryland 21215-0036 0 1 □Yes 🏖 No Specify: WHITE <u>ک</u> Specify: Year or Dates: WW II 3 X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) The Medical 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) LABORER 9 TIRE MANUFACTURING 7 is marked other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GRACE S. (LOWERY) HOLT ERNEST W. HOLT ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other to once. 27 DEBORAH MELLOTTE/DAUGHTER RR 4, BOX 77, RIDGELEY, 26753 WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem.Gdns. 08/22/09 LaVale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A 21502 Hwy., National LaVale, 23a. Part 1 Enter the disease, or complications that a used the death shock, or heart failure. List only one cause on e ich line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician PARKINSOMISM 6 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrier of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical the. attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) signed by the a the detached for P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed PNEUMONIA page 2 should CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 1 No 1 ☐ Yes 2 □ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA funeral 27. Manger of Death Date of Injury (Month, Day, Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: 🔟 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year)

6 mg

29b. Signature and title of certifier

32. Registrar's Signature

POONAI, VIKRAMADITYA, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502

2009

**ORIGINAL** 

29c. License number

D36766

29d. Date signed (Month, Day, Year)

20,200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6 0 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 22:25 **Physician** SANDRA KAY HOTT 2009 AUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY CUMBERLAND WMHS- MEMORIAL CAMPUS 8. Date of Birth (Month, Day, Ye Nov. 11, 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. 58 235-82-4356 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ral", or items 23a or 28a-f show Evanither at the notified at 1 ☐ Yes 2 X No Paw Paw Director WV Morgan the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA HC 60, Box 5 25434 Funeral death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. White § 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing 7 is marked other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Elizabeth Manning Cecil Floyd King, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Kealy Jo king - Daughter 765 Bethel Road Paw Paw. WV 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Aug.21,2009 Paw Paw, WV Camp Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Kimble Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Paw Paw, West Virginia Immediate Cause (Final disease or condition resulting in death) Physician CARBIOVASCULANZ UNKNOWN ATHEROSCHEROTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Examine attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RESPIRATORY FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐Yes 2 ☐ No CARCINOMA 1 □ Yes 2 🗖 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No f Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manner of De 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after death Director: d in by the ר 24 hours aft ie Funeral DI itetely filled ir within 24 ho

To the Function

completely

1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not be determined	(Month, Day, Year)  28e. Place of Injury - At houilding, etc. (Special	Injury M ome, farm, street, factory)	work? 1 □ Yes 2 □ No ory, office	28f. Location	(Street and Number or Rural Route Number, own, State)	
29a. Certifier (Check only one)	Certifying Physi	cian: To the best of my knoer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pon, in my opinion, death c	lace, and due to the courred at the time	he cause(s) and manner as stated. e, date and place, and due to the cause(s)	
29b. Signature and	title of certifier		2	9c. License number		29d. Date signed (Month, Day, Year)	

29c. License number

AUGUST 18, 2009 D 25406

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Lamm 900 Seton Drive Cumberland, MD

State Registrar

Medical

31. Date filed (Month, Day, Year)

Barke course

3

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 11, 2009 ear Madelyn Jane Josephson 5:30AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Months Days Hours Min. April 27, 1919 Pennsylvania 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1 □ M 2 🔽 F 187-01-7471 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyyYes 2 □ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15101 Interlachen Drive #221 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X☐ No If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent Department of the Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Rose Rose Snyder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Hyde Road Silver Spring, MD 20902 Richard Josephson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Kiffget Ward Tolly) (Name of Gardens Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Falls Church, VA 8/14/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Mem. Chapel 21. Signature of Funeral Service Licensee 1170 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 □Yes 🗷 🗆 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred

**Physician** /Medical Examiner Examine the Hospital or Attending Physician: The law requires that the death certificate be exect Physician/Medical þ

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Records,

Division of Vital

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**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

death with the Maryland

(b

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event, the Region Experience to actificate once.

Completed Be Certification: To within 24 hours after death

To the Funeral Director:
Campletely filled in by the

1 ☐ Yes 2 ☑ No 9 ☐ Unknown

25. Was case referred to medical 1∐ Yes 2.☑No 27. Mann of Death 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined

28b. Time of Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a, Certifier (Check only one) 29b. Signature and

31. Date filed (Month

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. dicertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Atul Rohatgi 8600 Old Georgetown Rd. ,Bethesda,MD 20814

State Registrar

10 D

32. Egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 11, 2009 Year **Physician** 5:35 A M JAMES RICHARD GARFIELD JONES, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Beltsville 5306 Brewer Rd Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 ☐ F Director 83 6/23/26 MD 217-44-0538 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Wedical Examiner must be notified at 1 X Yes 2 □ No Director Beltsville MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ò U.S.A. 20705 or items 23a 5306 Brewer Rd Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 XYes 2 ☐ No Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1945-1946 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3€ Widowed 4 Divorced "natural", Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician Federal Covernment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Jane Matthews John Henson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any Injury or other trau 5306 Brewer Rd, Beltsville, MD 20705 James R. G. Jones, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burian 2 ☐ Cremation 3 ☐ Removal fr 8/17/09 Maryland Nat'l Mem. Laurel, MD 4 □ Dorgation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signal Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com shock, or heart failule. List only, pications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final weeks **Physician** systemic inflamatory response disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** weeks aspiration pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) years dementia physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, þ Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Ö 1 □Yes 2 □No the 9 Unknown signed by the σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 diabetes mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? dementia/alzheimer's disease 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 █ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this eral Director: After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined after 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/12/09 D43575 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Dusen Rd, #130, Laurel, MD 20707 Angela Duncan 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State AUG 14 Registrar

09-06356 Otis Russell Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tis Russell Jones		State of Maryland / Department of Health and Mental Hy For State Certificate of Death		Reg. No.	200	19 2766
Physician			2. Date of Dea	ath	Year	3. Time of Death
ledical Examine		OTIS RUSSELL JONES	Month August 1	3, 2009		2015 hrs
	4	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Boute 4 North @ Sands Road  Lothian			inty of Death Arundel	
	Ļ	Note 4 Note & Garles Note	8. Date of B			hplace (State or Foreign
Funeral Director		578-92-7540 1X M 2 F 43 Yrs. Months Days Hours Min.	1	4, 196	Col	untry) RYLAND
á:	_	Jsual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-fshow any datonce.		MD PRINCE GEORGE CLINTON				1 X Yes 2 No
the Maryland a or 28a-f sh iffied at once	3 1	0e. Street and Number 10f. Zip Code		10g. Citizen	of What Cour	ntry?
the Man or 2	5	8916 GOLDFIELD PLACE 20735			S.A.	
eath with the Maryland items 23a or 28a-f sho		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	ecify Yes or N Rican, etc.)		Race - Ameri White, etc.	can Indian, Black,
or items 23		1 Never Married 2 A Married 1 Yes 2 X No		Spe	ecify: B	LACK
rs after d	<u></u> }-	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w	vork done		of Business/	Industry
2 hours af	- Jed	Elementary/Secondary (0-12) College (1-4 or 5+)	red)			
036 ithin 7 me. ne. ledica	Completed	12th COORDINATING SUPERVISO	OR	GOY	/ERNME	NT TN
17215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene han "natural", or items 23a or 28a-f she with the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last) OSCAR L. JONES SR.  18. Mother's Name DIANE PR		e, Maiden Sur	name)	ľ
Z 5 6 5 5 1	9 P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F		umber, City o	r Town, State	e, Zip Code)
MD 2 shou lth and N n 27 is n aumatic	-	PRECIOUS JONES/WIFE 8916 GOLDFIELD PLACE (				
4 E & E E	Ī	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Loc	ation - City or	Town, State
MOF Pages I ent of F int: If		1 X Burial 2 Cremation 3 Removal from State MOSES CEMETERY  4 Donation 5 Other Specify:	0-2009	LOTI	HIAN,	MD
Baltimore, permit. Pages la Department of He Important: If ite injury or other to	Ī	21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB				OME
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	ANDOVEI or respiratory	R, MD arrest, shock,	20785 or heart	Approximate Interval
Physician /Medical		failure. List only one dause on each line.				Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):				
		Sequentially list conditions, b				4
	<u>j</u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
ed nsit	Exa	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The aw requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this ertificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit.	ledical	d. UNPENDED AMENDED				
60, ate be		IF FEMALE: 23c. If yes, outcome of pregnancy			Date of delive	•
Sox 6876 death certificate e attending phy I for use as the l	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of death 5 Other (Specify)	ancy	I M	onth	Day Year
Box 68760, e death certificate be the attending physic of for use as the burner of the burner at the	Physician/N	1 Yes 2 No 9 Unknown g Unknown				
that the d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				o the cause of death?
ires th	d by					obably 4 Unknown autopsy findings available
tords, P aw requires the	Set			utopsy erformed?		completion of cause of
Reco	Completed			es 2 No	1 🗸	
Vital Rec hysician: The this ertificate	Be	25. Was case referred to medical examiner? Hospital: Inputient 2 FR/Outputient 3 DOA Other Nurs	k only one) ing Home 5	Davidana	ce 6 🗸 Oth	or: Sanna
f Vir	٥	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Outs'4 Nurs  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Descri	be how injury	occurred	
Division of Vital Records, P.O. Ital or Attending Physician: The aw requires that the safter death.  The division of the serificate has been signed by the funeral director, age 2 should be detacted in by the funeral director, page 2 should be detacted.	崩	1 Natural 5 Pending Aug 13, 2009 0000 hrs 1 Yes 2 No	Operator	motorcyc	le involved	d in collision
isio	ertification:	2 V Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locatio	on (Street and	Number or I	Rural Route Number, City
Div oital or urs aft	erti	4 Homicide determined (Specify) Major Road / Highway	Route 4 N	orth @ San		
Division of Vital Req within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral dire tor, page	alc	2ga. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and which occurred are the time, date and place, and one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the d	cause(s) and	manner as st	ated. the cause(s)
To th withir To th compl	Medical	one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier 29c. License number				Month, Day, Year)
	2	O.C.M.E.		Augu	st 14, 200	9
		30. Name and address of person who completed cause of death (Item 23a)				
R 5		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01			
Sta		31, Date filed (Month, Day, Year)  32. Registrar's Signature				
Regist	rar	AUG 1 7 2009 Jenus D. Jack				

09-06604 Ker

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nneth Jordan	1	State of Maryland / Department of Hea -For State Certificate of Dea	alth and Mental F a <i>th</i>	Hygiene Reg. N	. 2009 2768
Physicia	R	egistrar 1. Decedent's Name (First, Middle,Last)		2 Date of Death	3. Time of Death
edical Examir	ner	Kenneth Ray Jordan	, Town, or Location of Dea	Month Day August 23, 20	4c. County of Death
		4a. Facility Ivalle (Il flot libitation, give street and	timore	201	,
Funeral Director		· · · · · · · · · · · · · · · · · · ·	nder 1 Year   1f Under 24H https://doi.org/10.1001/10.	Hrs. 8. Date of Birth (Main. August 23	M/DD/YYYY) 9. Birthplace (State or Foreign Country)DeLaware
	1	Usual Residence of Decedent			10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town or Location Maryland Frederick K	noxville		1 Yes 2 X No
yland I-f sho	휘	Tiday I dila	Zıp Code	10g.	Citizen of What Country?
ne Maryland or 28a-f show any <u>fred at once.</u>	ie	1311 Lees Lane	21758		United States
with the	la l	If Voc on	edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue	( Specify Yes or No- erto Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
death or iten	FILE	1 Never Married 2 X Married 1 Yes 2 X No	2 X No specify:		Specify: White
rs after ural", miner	ā	3 Wildowed 4 Divorced or Dates: 16a Decedent's Usu	ual Occupation (Give kind	of work done	b. Kind of Business/Industry
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+) Highway a	working life. DO NOT use and Bridge	retired)	Construction
vithin ene	du		on Executive	ame (First, Middle, Mair	den Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	ပိ	17. Father's Name (First, Middle, Last)  Dewey Jordan	Rer	ne Weber	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Menla Hygiewith T's ris marked other than "natural", or items 23a or 28a-f sho rangic event, the Medical Examiner must be notified at once	일	19a. Informant's Name/Relationship (Type, Print )			r, City or Town, State, Zip Code)
MD id 2 shc llth and m 27 is			s Lane, Knoxvil	Date 2	Oc. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in Properties of Health and Mental Hygiera (Hiem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  Mount 01ivet 0	ace) /	August 27, 2009	Frederick, Maryland
ltim it. Pag rtment ortant: y or o		t S U E Other Cooping	*		
Ba perm Depa Impo	1	M01433 Reene	ast Church Str	eet, Frederic	k, Maryland 21701  shock or heart Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo- failure. List only one cause on each line.	ide of dying, such as cardi	iac or respiratory arrest	Between Onset and Death
Medical aminer		Immediate Cause (Final disease or condition resulting in death)  a. Contact Gunshot Wound of Head  Due to (or as a consequence of):			
		Sequentially list conditions b.			
	miner	if any, leading to immediate  Due to (or as a consequence of):		. <u></u>	
d sit	0	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
0, : be executed sician and burial - transit	edical E	d. UNPENDED AMENDED			
O. C. Box 68760, that the death certificate be execut ned by the attending physician and detached for use as the burial - trans	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery  Month Day Year
687 certific nding p	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal december 12 months? 2 Fetal december 13 Pregnant at time of death 5 Other	eath 3 Ectopic pr (Specify)	regnancy	World Bay
Box 6876  death certificate the attending phy ed for use as the le	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		. I 220 Did tob	acco use contribute to the cause of death?
F.O. ires that the signed by t	by P	Part II. Other significant conditions contributing to death but not resulting in the under	dying cause given in Part I		2 ✓ No 3 Probably 4 Unknown
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cords, law require has been see 2 should	Completed			autops perform 1 Yes 2	ned? death?
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Vita hysician this cer	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3			Residence 6 Other:
1 of Vital Rec ling Physician: The I After this certificate funeral director, page	l E	27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Rending 28b. Time of Injury (Month, Day Year) 1127 hrs	y 28c. Injury at Work? 1 Yes 2 ✔ N	Subject shot	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending phy completed effled in whe fumeral director, page 2 should be detached for use as the b	Certification:	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, fa		28f. Location (S	treet and Number or Rural Route Number, City
Div iital or urs afte ral Dii	ertif	Suicide 6 Could not be determined (Specify) Single Family			ate) eet, Buunswick, MD
D To the Hospital within 24 hours To the Funeral			at the time, date and place, in my opinion, death occu	ce, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To the within 7	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
	-	D-m - 1 m	O.C.M.E.		August 24, 2009
3		30. Name and address of person who completed cause of death (Item 23a)	long Circot Dolling	re MD 21201	
		Bottle III. Villooning III.2	enn Street, Baltimor	16, IVID 2 1201	
Regi	State istra	AIIE O E 2000 A A			
DHMH 17 Rev 1	1/2001	OCME ORIGINAL			

			State	e of Marylan	-			Mental Hyg	giene	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of	Deam	2. Date of Dea	Reg. No.	3. Time of Death
	Physici		Mary Ann Jasper					Month	Day Year 5/2009	1120 M
1	/Medio		4a. Facility Name (If not institution, give street as	nd number)		4b. City, Town, o	r Location of Dea		4c. County of Dea	
,,,,,	= Adiiii		Anne Arundel Medical	Center			napolis		Anne Aru	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)		If Under 24 Hrs Hours Min		h 9. Bir	thplace (State or Foreign
	Director		213-38-3551		67 Yrs.	IVIOIIIIIS Days	1 louis Will	1/27/19	942	MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ξ	MD Anne Arunde	1	Gambri	11s				1 □ Yes 2 K No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	puntry?
	th with		936 Fall Ridge Way			210	054		USA	
	ems	Funeral	11. Marital Status 12. Was	Decedent Ever in U.s ed Forces?	S. 13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No-	14. Race - Ame	
36	s after	by Fu	1 Never Married 2 Married 1 If Ye	Yes 2∏No s, Give		l∐Yes 2√∑No	Specify:	to Theati, etc.,		hite
0	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ont, it e Madical Examinat nast be malified at	pe pe	3 Ll Widowed 4 Ll Divorced Yea	r or Dates:						
5	in 72	Completed	15. Decedent's Education (Specify only highest grade comple		(Give	tent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Business	Industry
212	with jiene r thau	lmo	Elementary/Secondary (0-12) Colle	ege (1-4or 5+)		ecretary	*/	ŀ	Governm	ent
b	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Surname)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination ust be reallied at once.	To	Joseph Lynn				Mary I	rene Hobb	os	
a	2 sho is ma is ma		19a. Informant's Name/Relationship (Type. Print	•					r, City or Town, State,	Zip Code)
	1 and Health em 27 ther tr		Richard Jasper Spou		1				MD 21054	
altimore,	Pages nent of hant of hant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal	HOIII State		sition (Name of natory or other place		Date	20c. Location - City or	
≣	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	Atl		Crematory			Glen Burni neral Home	-
Ba	permi Depar Impor any Ir once.		3. J.						, MD 21401	, r.A.
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death	. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory an	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		+etri	ul Cu	ucor			Onset and Death
	/Medical Examiner		resulting in death)	ie to (or as a consequ						
	_xammer	<u>.</u>	Sequentially list conditions, b	un to /or en e connecu						
	uted d insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Obsease or injury that initiated events c.	ie to (or as a consequ	ence oi):					
o,	exec an and ial-tra	Exa	resulting in death) Last	ie to (or as a consequ	ence of):					
8760,	icate be executed physician and the burial-transit	dical	d							
တ		<b>a</b>	IF FEMALE:							
Box	eath certific attending p	an/l	23h Was decedent pregnant 23c. If ye	s, outcome of pregna Live birth 2 ☐ Fetal		Ectopic pregnanc	v		23d. Date of de	,
o	at the de by the a tached f	Physician/M	1 Type 2 MNo 4 L	Pregnant at time of de Unknown	eath 5	Other (specify) _			Month	Day Year
J.		P	Part II. Other significant conditions contributing	to death but not resu	Iting in the ur	derlying cause give	en in Part I,	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	w requires t s been signe should be o	by Dy						1 🗆 Y	es 2 No 3 P	robably 4 Unknown
ပ္က	law rec las bee 2 shou	Completed						24a. Was a	an 24b. Were a	itopsy findings available
ř	The law ate has bage 2 s	E						autop: perfor	sy prior to med? death?	completion of cause of
Ita	yslcian: The is certificate hidirector, page	BeC	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes ath (Check only or	2.No 1 ☐ Yes	2 □ No
010	Physician: r this certific ral director,	- 1	1 Yes 2 No Hospital:	1 npatient 2 1	ER/Outpatien	t 3 DOA Oth	or:		ence 6 ☐ Other (Spe	cify)
S C	ing P	ii o	1 Matural 5 ☐ Pending	Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	<b>i</b> ?	28d. Describe h	ow injury occurred	
<u>s</u>	ttend death ttor:	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
DIVISION	after Direc	Certification: To	4 ☐ Homicide determined 28e.1	Place of Injury - At hor building, etc. (Specify	me, tarm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	To the Hospital or Attending Physimitin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier (Check only one) 2 Medical Examiner: On	o the best of my know	vledge, death	occurred at the tir	ne, date and place	e, and due to the	cause(s) and manner a	s stated.
	thin 24	Medical	one) and 29b. Signature and title of certifier	manner stated.	——					
	₹.¥.50		21 TA	NA CONTRACTOR OF THE CONTRACTO		29c. Licens		2	29d. Date signed (Mont	n, ∪ay, 10ar)
		-	30. Name and address of person who completed	cause of death /Itom	23a) (Tuno 1	1) 2 8			, 10	1
L	45		30. Name and address of person who completed  Robert Person  31. Date filed (Month, Day, Year)  AUG 12 2009	A.A	MC	Ana	uncles	141	21401	
ľ	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	1	V /			
	Registra	ar	AUG 12 2009	Denova	B. x	Parker				

DHMH 17 Rev 1/2001

		ror	ertment of Health and Mertificate of Death	Mental Hygiene
Physi		1. Decedent's Name (First, Middle, Last) Shirley Kliger		2. Date of Death Month August 11, 2009  3. Time of Death 4:50 p
/Med Exam		4a. Facility Name (If not institution, give street and number)  Shady Grove Adventist Hospital	4b. City, Town, or Location of Death  Rockville	
Funera Directo	_	5. Social Security Number  099-05-2125  6. Sex 1 M 2 F 7. Age (In yrs. last birthday 91 Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Mental Everinat must be notified at	once.  To Be Completed by Funeral Director	11. Marital Status  1	burg  10f. Zip Code  20878  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1	Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Own Home  Dinik  ral Route Number, City or Town, State, Zip Code)  cmingham, Michigan 48009  Date  20c. Location - City or Town, State
that the death certificate be executed that the death certificate be executed that the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	d	Stroke  B Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate has been signed by the attending physician: The law requires that the death certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1	26. Place of Deat  ient 3 □ DOA Other: 4 □ Nursing Ho  of 28c. Injury at Work?  M 1 □ Yes 2 □ No  street, factory, office  ath occurred at the time, date and place	24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   2   Unknown autopsy performed? 1   Yes   2   2   No   1   Yes   2   No    24b. Were autopsy findings available prior to completion of cause of death? 1   Yes   2   No   1   Yes   2   No    25d. Describe how injury occurred  28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29d. Date signed (Month, Day, Year)
Regi	State	30. Tame and address of person who completed cause of death (Item 23a) (Type Shahryar Davari, MD, 9901 Medical Ce 31. Date filed (Month, Day, Year) 33. Registrar's Signature	enter Drive, Rockvi	ille, Maryland 20850

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Physici

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	State of Maryland / Dep	artment of Health and Natificate of Death	Mental Hygiene Reg. No. 🦈 🗇									
cian	1. Decedent's Name (First, Middle, Last)  Karam Kaur		2. Date of Death Month Day	3. Time of Death 2009 7:51 P M								
ical iner	4a. Facility Name (If not institution, give street and number) 2996 Manchester Road	4b. City, Town, or Location of Death Manchester	4c. County									
	5. Social Security Number 215–47–1163 6. Sex 1 □ M 2X F 7. Age (In yrs. last birthday, 82 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) Oct. 15, 1926	9. Birthplace (State or Foreign Country) India								
tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit  Maryland Carroll County Manchester 1Xi yes 2□N											
al Director	10e. Street and Number 2996 Manchester Road	What Country?										
ed by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Specia	ce - American Indian, ack, White, etc. fy: Asian Indian Business/Industry								
Completed	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired) emaker	own hor									
To Be C	17. Father's Name (First, Middle, Last)  Jagat Singh	18. Mother's Nam Sama Kai	e (First, Middle, Maiden Surnai ur	me)								
		ing Address (Street and Number or Rui 5 Manchester Road		n, State, Zip Code) Maryland 21102								
	20a. Method of Disposition  1 Rurial 2 V Cremation 3 Removal from State  20b. Place of Disposemetery, cre-		16	- City or Town, State ead, Maryland								
	21. Signature of Funeral Service Licences  M01072  22. Name and Address of Facility Eline Funeral Home  M01072  934 South Main Street Hampstead, Maryland 21											
dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	1000000		Approximate Interval Between Onset and Death A VEMAS								
Be Completed by Physician/Me		□ Ectopic pregnancy P \ D \ □ Other (specify)		ate of delivery Ionth Day Year								
ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of  1 yes 2 No 3 probably 4											
Complet			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No								
Be (	25. Was case referred to medical examiner?		th (Check only one)									
Medical Certification: To	Hospital:   I   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)											
Certific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number City or Town, State)											
edical	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, deal can be seen to my											
Ň	29b. Signature and title of certifier	29c. License number		ed (Month, Day, Year)								
	30. Name and address of person who completed cause of death (Item 23a) (Type SURENDR) D. MORTRRA 3000  31. Date filed (Month, Day, Year) 32. Registrar's Signature		H) MANCHERTE	ER, MD. 21102								
tate trar		pare	·									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		1	Inspiritude of Maryland / Department of Health For State Certificate of Death egistrar		Reg.	No.	3. Time of Death
Medi	Physicia ical Examii	-	Decedent's Name (First, Middle,Last)		Month Da August 9, 20	ay Year 109	1259 hrs
1	loai Exami		Raymond Harris Levenson  Ia. Facility Name (if not institution, give street and number)  4704 PDDIe RDad  4b. City, Tot Sykesv	wn, or Location of Death		4c. County of Death	
	Funeral Director		Special Security Number 2 1 4 5 0 - 1 4 5 1	1 Year   If Under 24Hrs.   Days   Hours   Min.	8. Date of Birth (I	Foreig	thplace (State or gn strington DC
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	faryland 28a-f show Lat once.	ō	MD Caroll Sykesville		100	Citizen of What Cou	
	the Mary a or 28a- tified at	ı	704 Poole Road	1784		U.S.A	. •
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygenia. In tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Yes 2 XX No	nt of Hispanic Origin? (Spec Cuban, Mexican, Puerto Ri	cify Yes or No- ican, etc.)	White, etc.	rican Indian, Black,
	hours afte 'natural'', Examiner	<u>S</u>	or Dates:  15 Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual O	Occupation (Give kind of wo		6b. Kind of Business	·
	336 thin 72 ne. than '	Completed	5+ Teacher				ation
	21215-0036 suld be filed within 7 Mental Hygiene. marked other that ic event, the Medics	Be Cor	17. Father's Name (First, Middle, Last) Sidney Levenson		ulicove	c	
	MD 21 id 2 should b lith and Mer m 27 is mar aumatic ev	2	Susan Levenson/Sister 5707 Brewe	(Street and Number or Ru r House Circ	1e #201	Rockville	e, MD 20852
	nore, I ages I and ent of Healt nt: If item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Nam crematory or other place) National Crem			20c. Location - City of Falls Chur	
	Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr	1 10	21. Signature of Funeral Service Licensee 22. Name and A	Address of FacilityDanz		_	_
	Physician	-	3a. Part Later the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.	of dying, such as cardiac or	respiratory and	€ shock, or heart	Approximate Intervi Between Onset an
	/Medical :aminer		Immediate Cause (Final disease or condition resulting in death)  a. AtherDsclerDtic Cardiovascular Disease  Due to (or as a consequence of):				Death
		er	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
B	nted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence of):  d.				
	60, ate be executed hysician and e burial - transit	Medical	UNPENDED X, AMENDED #50PETCH, 8-18-09, BMW, McCo				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spec	3 Ectopic pregnar	ncy	23d. Date of delive Month	Day Year
	Bo he deat y the at hed for	hys	1 Yes 2 No 9 Unknown g Unknown  Part II. Dther significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
	ires that signed b						robably 4 Unknow
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled.	_			24a. Was a autops perform	med? prior to death	
	Vital Rec ysician: The his certificate director, page	ပ္ပိ	25. Was case fereited to friedical	26 Place of Death (Check of			
	Vita hysicia this ce	To Be	1 Yes 2 No		3	Residence 6 🗸 Otl ow injury occurred	her: Scene
	n of Niding Ph. h. : After t		27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury	28c. Injury at Work?  1 Yes 2 No	Zod. Describe ii	ow injury occurred	
	Division pital or Attend ours after death teral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory	y, office building, etc.	28f. Location (S or Town, St		Rural Route Number, C
	Division To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one)  Wedical Examiner: On the best of my knowledge, death occurred at the one)	e time, date and place, and ly opinion, death occurred a	due to the cause	e(s) and manner as s and place, and due to	stated. the cause(s)
		Medical	and manner stated.	c. License number		29d. Date signed (	Month, Day, Year)
	20		0_100	O.C.M.E.		August 10, 20	09
				Street, Baltimore, M	D 21201		
	Regi	tate	10 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMENDED PER FH 08/21/09 #20 Certificate of Death FCHD/ KB 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** 1:30 P. Larkin Virginia 13, August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Adamstown Buckingham's Choice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 1 F 79 Yrs. 2 203-22-4993 Pennsylvania Director February <del>1930</del> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show id other than "natural", or items 23a or 28a-f show event, the Medical Evancian in as be recified at 1√Yes 2 No Directo Maryland Frederick Adamstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2622 Inwood Road 21710 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify. white \$ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnet. College (1-4or 5+) Teller Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Douglas, Sr. Bessie Brice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2622 Inwood Road, Adamstown, Maryland Michael Larkin - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Immacurate Concepted on Cem 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Cemetery 8-18-2009 Washington, Pennsylvania 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service-Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death Immediate Cause (Final Concer **Physician** disease or condition resulting in death) /Medical Due to (or as a constinue of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.O. cate has been signed by the a page 2 should be detached it ☐Yes 2☐Mo 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe certificate 1 Yes 2 No 1 □Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place \_\_\_eath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8-13-6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 195 shall

State Registrar 31. Date filed (Month, Day

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14 2009

32. Registrary Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Sep 24, 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1929 Months Days Hours 1 M 2 □ F 215-26-1184 79 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shov Examirer must be notified at 1 ☐Yes 🎾 No Director Carroll Taneytown Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21787 2207 Feeser Road N USA by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Manufacturing 8 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be purmit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If Item 27 is marked oth any july or other traumatic even once. Pages 1 and 2 should be nent of Health and Mental Margie Ecker Jesse W. Little ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 948 Hughes Shop Road, Westminster, MD 21158 Wayne E. Little, son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Keysville Union Cem 8/14/2009 Keymar, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 22. Name and Address of Facility
Myers—Durboraw Funeral
136 E Baltimore St, Taneytown, MD 21787 Home Approximate Interval Between Onset and Death 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 12 hours 1 RACIONIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YPERIENCE Completed by Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2.X No 2 1 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)

lor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeatid director, page 2 should be detached for use as the burial-transit in the young the property. P.O. Box 68760, Division of Vital Records,

To the Hospital of within 24 hours at To the Funeral D

WIL 24

> State Registrar

Medical

4 Homicide

(Check or one)

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signat

title of certifier

29c. License number 63939

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print) SCREENE S+ Baltrmore, MD

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Oldio of IV	iai yiai i		rtificate of			Reg. No.	19 27672
	Physici	an	1. Decedent's Name (First, Middle,	, Last) Charlott	e	LoBaug	⊃h		2. Date of Dea Month	Day Ye	3. Time of Death
	/Medio	cal	4a. Facility Name (If not institution,					r Location of Death	August	10, 2009	11:20A.
1	Examir	ner	Summerville @				Bowie	LOCATION OF DEATH			Georges
	Funeral Director			6. Sex 7. A		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day June 2	y, Year)	Birthplace (State or Foreign Country) Pennsylvania
	and w		Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	ocation				10d. Inside City Limits
	ne Maryla 18a-f sho	ector	Maryland Princ	e Georges	Bow						1X Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 14997 Health Ce				10f. Zip Code 20716			10g. Citizen of Wha	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Modical Examiliar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces ed 1 Yes 2 X If Yes, Give Year or Dates	? ] No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Black, \ Specify:	American Indian, White, etc.  White
15-	"natu	lete	15. Decedent's (Specify only highest	's Education t grade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work	ing	16b. Kind of Busin	ess/Industry
2121	filed within Hygiene. Ither than than and the than than than than than than than than	Completed	Elementary/Secondary (0-12) 12	College (1-4or	5+)		nemaker	u)		Own Hom	ie
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It was	To Be C	17. Father's Name (First, Middle, L Charles F.					18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ary	2 shou and M Is mar	۲	19a. Informant's Name/Relationsh	ip (Type. Print)		1	•			er, City or Town, Sta	
	1 and 2 Health erm 27 I		Fred LoBau	gh Son							rg, Va 22407
altimore,	nit. Pages 1 artment of the ortant: If ite injury or ot injury or ot e.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		Twi	n Vali	osition (Name of matory or other place) Ley Mem.	<sub>Park</sub> 8/14	Date / 2009	20c. Location - Cit	Pa.
Ball	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Servicest.	ioensoe		2:					neral Home yland 20715
			23a. Part 1. Enter the disease, or c shock, or heart failure. List of	complications that cause only one cause on each	ed the death line.	. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	687	110	FORS	KAI	ea TES		Onset and Death
	Examiner		,	Due to (or a		ience of):	110				1 wx
	D #	ner	Sequentially list conditions, if any leading to innectiate cause. Enter Underlying Cause (Disease or injury	Directo for a	я попесц	iance off:					
	rtificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	20 ~ /	c C	HETTO	CTIVE	Pur	n. 715	· 10 y 755.
68760,	e be ex sician burial			Due to (or a	s a consequ	ience orj.					
687	tificate ig phy as the	Medical		- a						1	
.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendir all director, page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2   Fetal	death 3[	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of Month	
о, О,	s that gned b e deta	by Pt	Part II. Other significant condition	ns contributing to death	but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
ord	v require been się should b		MUPERTO	CNSION	<u> </u>				1 🗆 Y	′es 2 No 3[	☐ Probably 4丛Unknown
of Vital Records,	The law rate has be page 2 sh	Completed	-						24a. Was a autop perfor 1 □Yes	rmęd/ dea	re autopsy findings available r to completion of cause of th? Yes 2 □No
Vita	ysician: T is certificat director, pa	Be (	25. Was case referred to medical examiner?	Manitali			Tou	26. Place of Deat			
	Physic rules of the real direction	1: To	1 Yes 2 No 27. Manner of Death	28a, Date of In	iurv	ER/Outpatie 28b. Time o	nt 3 DOA Oth	4 Li Nuising n		dence 6 XOther now injury occurred	(Specify)
ion	Attending r death. sctor: After oy the funer	ation	1 Natural 5 Pending 2 Accident investige	(Month, D	ay, Year)	Injury	Wor	k?  Yes 2 □No	Zod. Describe ii	ion injury occurred	
-	- a	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	20e. Place of it	njury - At ho tc. <i>(Specif</i> y	me, farm, sti	reet, factory, office		28f. Location (S City or Tow	Street and Number ( vn, State)	or Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)	g Physician: To the bes Examiner: On the basis and manners	of examinat	wledge, deat tion and/or in	th occurred at the ti	me, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and manr date and place, and	ner as stated. If due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2			29c. Licens	e number	:	29d. Date signed (	
N	45		30. Name and address of person w	who completed cause of	death (Item	23a) (Type,	Print)				
	Sta	te	Morraus  31. Date filed (Month, Day, Year)	32. Begis	trar's Signat	ture	1016/	-01651	PR.	ANNA	Pocis, mp
	Registr		AUG 12	2009 32. Pegis	un ,	A. 14	all				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line b-d, PII, per MD 8896 10/21/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11 2009 Physician JOHN ALBERT LUCAS, JR AUG 8:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days Hours 1 ☑ M 2 🗆 F Yrs 042-34-9837 Connecticut Jan. 19, 1943 Director 66 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hyglene.
em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Eventual to a nutilial at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No r than "natural", or items 23a or 28a-f sl Director VA Fairfax McLean 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1079 Old Cedar Road 22102 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 Nol 966− If Yes, Give Year or Dates: 1985 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Lucas Isabel McCrecken ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret-Alice Lucas/Wife 1079 Old Cedar Rd., McLean, Va. 22102 item 27 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State = 5 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State December 18 Department or Important: If any Injury or once. Arlington National 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, Va. 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home MO1315 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Complications of hypoglycemic shock Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed esophageal leak attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, para-esophageal hernia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ cate has been sig , page 2 should b 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 🗌 Unknown HYPOGLYCEMIA RESULTING IN PERSISTENT VEGETATIVE STATE 24b. Were autopsy findings available prior to completion of cause of death? Mesh placement for hernia 24a. Was an autopsy 2 ី No 1√2Yes 2□No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 

I Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√∑ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a Funeral I 29a. Certifier To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August, 12, 2009 01055104A (IN) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) AUG 27 Barket

MICHAEL BAYDARIAN LCDR MC USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

DHMH 17 Rev 1/2001

NU

			1 - For State of Maryl Registrar	•	rtificate of D			ene g. No. 🤈 🔒 👭 🔾	27674
	Physici	an	1. Decedent's Name (First, Middle, Last)  Catherine Marie McGuire				2. Date of Death Month August	Day Year	3. Time of Death
and the	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo	ocation of Death	August	4c. County of Death	3:15 Am
			583 Wayward Drive		Annapolis	6 If Under 24 Hrs.	O Date of Dinth	Anne Arur	
	Funeral Director		5. Social Security Number 215-05-5578	yrs. last birthday) _ Yrs.		Hours Min.	8. Date of Birth <i>Month Day</i> 10/10/1	Year) 917 Balt	place (State or Foreign ntry) Cimore, MD
	yland how			c. City, Town or Loc	ation			1	0d. Inside City Limits
	Ba-f sl	ector	MD Anne Arundel	Annapol:					1 □Yes 2 No
	h with ti	al Dir	10e. Street and Number 583 Wayward Drive		10f. Zip Code 21401		10	g. Citizen of What Cour USA	ntry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemities must be troutled at once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	1	Vas Decedent of Hisp Yes, specify Cuban, □Yes 2ᡌNo	panic Origin? (Spe Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
15-0	72 ho	leted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupati kind of work done dur DO NOT use retired)	on ring most of workin	ng 1	6b. Kind of Business/In	dustry
212	within jiene.	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	_	non use retired)			Food Servi	ce
Maryland 2	ld be filed lental Hyg <b>ked othe</b> ic event,	To Be C	17. Father's Name (First, Middle, Last) John Lingenfelder		1	8. Mother's Name Catheri	(First, Middle, Ma ne Barne		
lary	2 shour and Missing mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	g Address (Street an	d Number or Rura	l Route Number,	City or Town, State, Zip	Code)
	1 and Health em 27 other to		Calvin McGuire Son  20a. Method of Disposition 20		Wayward Sition (Name of			MD 21401  Oc. Location - City or To	own. State
Baltimore,	t. Pages tment of tant: If it		4 Donation 5 Other (Specify)	Baltimore	sition (Name of latory or other place)  National	8/11/		saltimore,M	
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee		Name and Address ardesty Fu		me P.A.	12 Ridgel Annapolis	ум <mark>ф</mark> vе 1401
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the candidate cause of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	RACER nsequence of):	er the mode of dying,		r respiratory arres		Approximate Interval Between Onset and Death
68760,	rificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a condition)  C.  Due to (or as a condition)	sequence of):					
P.O. Box 6	ath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of prediction in the past 12 mophs? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
rds, F	quires that the de in signed by the a uld be detached t		Part II. Other significant conditions contributing to death but not	resulting in the und	derlying cause given	in Part I.		acco use contribute to t	he cause of death?
al Records,	ician; The law requir certificate has been si ector, page 2 should b	Completed by					24a. Was an autopsy perform	prior to co death? ☐No 1 ☐ Yes	opsy findings available mpletion of cause of
f Vital	hysician; nis certific director, I	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 3	2  ER/Outpatient	Othor	<ol> <li>Place of Death</li> <li>Wursing Hon</li> </ol>		nce 6 Other (Speci	fv)
	ing Affer une	ion:	27. Mann Death 28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	28c. Injury a Work? M 1 □ Ye		8d. Describe how	v injury occurred	,,
Division	a ta :: e	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre pecify)		s 2 🗆 No 📗 2	8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
_	Hospita Hospita Hours Funeral tely fille	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examone)  29a. Certifier and manner stated.	knowledge, death mination and/or inv	occurred at the time restigation, in my opir	, date and place, a nion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due to	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License r	number	29	d. Date signed (Month,	Day, Year)
			m	MI	DS	5224	SA	ryust 10	2009
7	15		30. Name and address of person who completed cause of death (	(Item 28a) (Type, P	G DEES	NSS He	LuAn	Suda UM	Anopuls MD 214
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 12 2009  32. Fegistrar's Si	ignature	enter	<i></i>		ne 100	2170

State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per per per 1897,08/28/29/dhb Amend Items 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Peter A. Mangold 10 2009 0540 A June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Hospital E1kton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 27, 1910 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 X M 2 □ F Yrs 99 Pennsylvania Director 166-01-1727 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County "natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 ☐ Yes 2 ▼ No Directo Maryland Ceci1 Colora 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 52 Curtis Lane 21917 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 to No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Police Chief Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Mangold Jenney M. Andryitis other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.9 Department of Health a Important: If Item 27 Is any Injury or other tra Ada Henderson/Sister 52 Curtis Lane, Colora, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place)
Siloam United Methodist 20c. Location - City or Town, State 20a. Method of Disposition June 13 1 Burial 2 □ Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Church Cemetery 2009 Garnet Valley, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licenses 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** androveshivat /Medical Due to (or as a consequence of): Examiner 751S Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine SERTIFICATION APPROVED BY MEDICAL EXAMINER the death certificate be executed Due to (or as a consequence of) burial-tra P.O. Box 68760. Physician/Medical the as attending p IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No ed by the a 9□Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe 1 Yes 2 No or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examinor: 14 Yes <del>£ X</del>No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2X No 04/16/2009 Unknown<sup>M</sup> Subject slipped and fell. 2X Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 52 Curtis Lane. determined 4 Homicide Home To the Hospital o within 24 hours aft To the Funeral Di Colora, MD tix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce tifier 29c. License number 6110 30. Name and address of person ted cause of death (Item 23a) (Type, Print) 6 M.D., 107 Bridge Street, Elkton, MD 21921 31. Date filed (Mo State Registrar

DHMH 17 Rev 1/2001

ate of Maryland /	Department of Health and I	
	Cartificate of Dooth	

		1 - For State Registrar		y	Certificate	of Death	R	eg. No.	n - 15 3 20 1	
Physicia	an	1. Decedent's Name (First, Middle, Las		CD			2. Date of Deat Month AUGUST	23 2009	3. Time of Dea	
/Medic	cal	ROBERT CHARLE  4a. Facility Name (If not institution, giv.		SR.	4h City To	n, or Location of Dea		4c. County of D		a™
Examin	ier	Chestertown Nurs		ilitat		tertown		Kent		
Funeral Director		203-24-2047		In yrs. last bir	thday) If Under 1 Yrs. Months E	ear   If Under 24 Hr ays   Hours   Mir		1930 P	Birthplace (State or Fo Country) Pennsylvani	
land ow		Usual Residence of Decedent  10a. State •10b. County	11	0c. City, Towr	n or Location				10d. Inside City L	imits
Mary a-f sho	tor	MD Kent		Mill	ington				1 □ Yes 2	<b>S</b> No
h with the 23a or 28a st be not	al Director	10e. Street and Number 31815 River Park	Rđ.		10f. Zip Co	de 551	1	0g. Citizen of What U.S.A.	Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I' a Medical Examinal must be notified at once.	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Deceden If Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)	Black, W	merican Indian, hite, etc. White	
72 hou	eted	15. Decedent's Ec	lucation de completed)	16a.	Decedent's Usual C	one durina most of w	orkina ı	16b. Kind of Busine	ss/Industry	
within ene. <b>than</b> "	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	0	life. DO NOT use i	etired) n <b>trol Engi</b>	neer	Electron	ic Manufac	rtur
filed v Hygie other 1	မ င	17. Father's Name (First, Middle, Last)		2	darrey co.		ame (First, Middle, I		TO TRATICAL CO	CUL
Alental Alental rked c	To B	Royal V. Miller				Emma 1	Blauser			
2 shou and h is ma		19a. Informant's Name/Relationship (		- 1		reet and Number or f				
l and lealth	Ļ	Craig Miller	(son)		31815 Riv	er Park Rd		gton, MD.  20c. Location - City		
: Pages tement of tement of tement of the tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		Kent	ry, crematory or other Cremation	8/2	24/09	Smyrna,	DE.	
permit Depar Impor any in		21. Signature of Cuneral Service Licey		00510	Galena 118 Wes	Horess of Facility Funeral Ho t Cross St	ome of Ste . Galena	ephen L MD. 216	Schaech 35	
Physician /Medical Examiner	J.	23a. Part Enter the Isease, or com sock, or lart failure. List only Immediate Couse (Final disease or andition resulting in death)  Sequentially list conditions,	a	onsequence	W Carcin	-	ac or respiratory arr	est,	Approximate Interval Betwee Onset and Dea	en ith
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
at the death certific by the attending p tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic prec 5 ☐ Other <i>(spe</i> c			23d. Date of Month	delivery Day Yea	ır
equires that een signed b ould be deta		Part II. Other significant conditions of Metastares to Bo	ontributing to death but r		the underlying caus	e given in Part I.			e to the cause of deat Probably 4 Unk	
: The law requ	Completed by	Dys hipideria, H	TN		· .		24a. Was a autops perfort	sy prior		ilable se of
ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Hospital:				eath (Check only or			
Phys r this ral dir	٦.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient		tpatient 3 □ DOA	Other: Nursing Injury at Work?		ence 6 Other (8	Specify)	
nding Fath. r: After e funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) l	njury M	Work? 1 □Yes 2 □ No				
al or Atte s after des I Directo d in by th	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, fa (Specify)	rm, street, factory, o	fice	28f. Location (S City or Town		r Rural Route Number	г,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, to	edical C	29a. Certifier Check only one) 1 Certifying Pr	nysician: To the best of a niner: On the basis of ea and manner state	xamination an	e, death occurred at nd/or investigation, in	the time, date and pla my opinion, death oc	ce, and due to the c curred at the time, c	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
To the within To the Comp	Me	29b. Signature and title of certifier	2 /		29c. L	icense number	2	29d. Date signed (M	onth, Day, Year)	
		> Mm/	M.M	)	10	64388	8	7/24/24		
		30. Name and address of person who	/							
		Matthew J. King, 31. Date filed (Month, Day, Year)	M.D. 120 S		Rd. Cheste	rtown, MD.	21620			
Sta Registr		AUG 27 2	1009 Jensen	U A.	franks					

		1 - For Amend Items Registrar	3 Z3a,Pt1,Z3	per me,	Sertificate of	Death	R	eg. No.	0.0	2767
		1. Decedent's Name (First, Middle	e, Last)				2. Date of Dear	th Day	Voor	3. Time of Death
Physici /Medi		LAW PENCE	R NEED	Y			Month	26 21	Year DO9	0104A
Examir		4a. Facility Name (If not institution	n, give street and number)	/	4b. City, Town, o	or Location of Death		4c. County	of Death	
		UNIVERSITY OF	F MARYLAN	DMED	ICAZ CTR	BALT	TMORE			
Funeral		5. Social Security Number		(In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpl	ace (State or Foreigi
Director		213-40-4388	IAIM ZLIF	57 Y	rs.		July 12			yland
m w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10	d. Inside City Limits
larylan show	ō								'`	1 ☐ Yes 2 ☐ No
the M	Director		ington	над	10f. Zip Code		T	On Citizen of V	Mhat Causi	Δ
a or		10e. Street and Number			Tot. Zip Code			0g. Citizen of V	viiat Coun	uyr
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, Ite it office! Evaring a must be redified a	Funeral	17015 Burwood Co	ourt 12. Was Decedent Ev	raw in LLC	217		acifu Van ar Na	U.S	e - America	an Indian
item item	Ę.	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Forces?		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	an, Mexican, Puerto	Rican, etc.)		k, White, e	
rs af	by	3 ☐ Widowed 4 ☐ Divorced	ied 1 □Yes 2 □ No If Yes, Give Year or Dates:	´	1 □Yes 2□No	Specify:		Specify	· W1	nite
2 hou		15. Decedent	t's Education	16a. E	Decedent's Usual Occu	pation		16b. Kind of Bu	usiness/Ind	ustry
in 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed)  College (1-4or 5+)		Give kind of work done life. DO NOT use retire	during most of work d)	ing	_		-
y with	E O	12	College (1-401 5+)	'	Electri	cian		Ele	ctri	cal
be filed within 72 hotal Hygiene. ed other than "natu event, Its Medical	Be	17. Father's Name (First, Middle, I	Last)			18. Mother's Name	e (First, Middle, I	Maiden Surnam	ie)	
2 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", or aumatic event, Ire Modical Evant	70 E	Clarence E.	Needy			Maril	yn M. F.	leagle		
2 should n and Mer is marke raumatic	11	19a. Informant's Name/Relationsh	nip (Type. Print)	19b. N	Mailing Address (Street	and Number or Rui	al Route Number	r, City or Town,	State, Zip	Code)
and 2 ealth m 27 i		Sharon K. Needy	y (Wife)	170	15 Burwood	Court Had	erstown	.Md. 21	740	
of He item		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other pla	_ [	Date	20c. Location -		wn, State
Pages nent of int; If it iry or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp			burg Crema			Smiths	bura	.Md.
permit. Pages 1 and 2 should be Department of Health and Menta Important; if item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service L	Licensee		22. Name and Addre					
o a la co		Tolles /	Drvis	MO1414	J.L. Davis	s funeral	Home Sm	525 Bra	dbury	Ave.
		-29 art 1. Enter the disease, or shock, or heart failure. List of	complications that caused th	ne death. Do no	t enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	-	Approximate Interval Between
Physician		Immediate Cause (Final	only one cause on each line.	Mult	iple Centra	al Nervous	System		ts	Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of	Repair of	Abdomina			em .	CANCI
Examiner			REAL	0	1 1100	CHINO HE	Anari	4 In	CH 4	- DAYS
	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to ( r as a c		:		7,0,0,		1	15000
executed n and ial-transit	Examiner	that initiated events	AVETHE	NOSCI	Enone	CAMDIO	MECULA	n Disi	136	ACHIES
be executed ician and burial-transit		resulting in death) Last	Due to (or as a c	consequence of)	:	anna	e Here	EXUMINER		
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n ce use	200	IE EELAALE.			(	CATCOIGN CERTIFICATION APPR	JAED DI			
± 9 L	au'	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				7450 B	23d. Dat	te of delive	*
death certifii ne attending p ed for use as	sician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _		7450 01			ry Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 13, 2009 **Physician** Virginia Charlotte Ornick 4:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9804 Merwood Lane Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Vear Months Days Hours 1 ☐ M 2 🔀 F 577-10-3375 Director 91 Jan. 6, 1918 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Maryland Montgomery Silver Spring Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or 9804 Merwood Lane 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accountant Department of the Navy other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter E. Ferris Minnie O. Unknown ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie LaCouture/Granddaughter 9804 Merwood Lane, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug. 2009 17, PD Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Idiopathic Thrombocytopenic Purpura 2 years /Medical Due to (or as a consequence of): Examiner Failure To Thrive Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Ye the Funeral Director: After this certificate has been signed by the attending should and physician and the burial-transit Sacral Decubitus Ulcer 2 months Due to (or as a consequence of): Box 68760. Physician/Medical ending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation hin 24 hours after death, the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Theodore Igwebe, MD

AUG 14 2009

31. Date filed (Month, Day, Year)

D52927

1500 Forest Glen Road, Silver Spring, MD 20910

August 13, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August Day 200°9 4:10A M Thomas Pack 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Dec 27 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1**∑** M 2□ F Months Days Hours 1963 213-88-2388 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Annanolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Peters Way 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married If Yes, Give Year or Dates: 1 □Yes 2√□No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>TGI Friday's</u> <u> 12th</u> n Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William H. Pack Christine Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Pack(Wife) Peters Way Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary Church 8-12-09 Arnold, Md. Manuame Rose of Secul Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 0 MOC/8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final teriosc disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Dav 5 ☐ Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown 24a. Was an

**Physician** /Medical Examiner

Department of Heali Important: If item 2 any injury or other: once.

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

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Completed

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**Funeral** 

Director

2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f show raumatic event, the McJicil Examiner must be notified at

s 1 and 2 should b f Health and Ment tem 27 is marked

Pages 1

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Physician: The law requires that the death certificate be

Hospital or Attending

certificate

ner

ttending physician and for use as the burial-transit Exami Physician/Medical been signed by the should be detached ģ Completed cate has within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Medical

State

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

> autopsy performed 1 ☐ Yes 2 🗷 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1XYes 2 □ No 27. Manner of Death 1 Natural

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 4 | Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Deput

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

30. Name and address of person who completer cause of death (Item 23a) (Type, Print) IONES M

31. Date filed (Month, Day, Year,

32. Registrar's Signature

within 2 To the I

			For AMEND#19a per FH State Registrar 8/14/09 AACO HEA	State of Maryland LITH DEPT. CMH	d / Depa <i>Cei</i>	artment of H rtificate of I	lealth and N D <i>eath</i>		iene eg. No. 🤈 🕦 [	0 07686
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edward Eugene Proko	p				2. Date of Deat Month Aug •		3. Time of Death 99 7:30P. M
**	Examin		4a. Facility Name (If not institution, give stre 1164 Mainsail Drive			Annapoli:			4c. County of Anne Ar	Death cundel
	Funeral Director		5. Social Security Number 202-10-3697  Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	If Under i Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 29		Birthplace (State or Foreign Country) Cennsylvania
	e Maryland la-f show	ctor	10a. State 10b. County  Maryland Anne Arund		, Town or Lo			-		10d. Inside City Limits 1 ★ Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 931 Edgewood Road			10f. Zip Code 21403		1	0g. Citizen of Wha	•
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, it a "redical Exam is activated to once.		THI WATER CHARGE	Was Decedent Ever in U.s Armed Forces? XXIYes 2 □ No If Yes, Give Year or Dates: 42-4		Was Decedent of H fYes, specify Cuba 1 □Yes 2☑∭wo	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- b Rican, etc.)	Black, 1	American Indian, White, etc. White
21215-0036	J within 72 ho giene. r than "natu ine Medical	Completed by	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of worl	king	16b. Kind of Busir uilding	Industry
	ould be filed Mental Hyg arked othe atic event,	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
Maryland	should and Mer s marke	욘	Joseph Prokop  19a. Informant's Name/Relationship (Type.  Jacqueline Billingsley-l	Print)	19b. Mailir	ng Address (Street		ia Csigas ral Route Number	City or Town, St	ate, Zip Code)
	ages 1 and 2 nt of Health and 1: If item 27 is 7 or other tra		Jaz <del>ueline Billings1</del> 20a. Method of Disposition XXXXBurial 2 ☐ Cremation 3 ☐ Ren	ey/daughter 20b. P	lace of Dispo emetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location - Čit	
Baltimore,	permit. Pages 1 Department of F Important: If ite any injury or ot once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	ALI	22	Crematory 2. Name and Address 6000 Anna	ss of Facility	Robert E	. Evans	nie, Maryland Funeral Home and 20715
8760,	Physician and Medical Examiner sthe burial-transit	dical Examiner	resulting in death)	tions that caused the death- cause on each line.  Congestive H  Due to (or as a consequence of the condent of t	eart F uence of): ery Di uence of):	ailure	ig, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending ral ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	•
ords, F	w requires that been signed I should be deta	þ	Part II. Other significant conditions contributions. Hypertension, Hyper	•	J	, 0				ute to the cause of death?  Probably 4 Unknown
of Vital Records,	sician: The law re certificate has be rector, page 2 sho	Completed						24a. Was a autops perforr 1 □ Yes 2	y prid ned? dea	re autopsy findings available or to completion of cause of ath? IYes 2 □ No
	ing After une	ation: To Be	1 les 22110	pital: 1   Inpatient 2   28a. Date of Injury (Month, Day, Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Worl	er: 4 ☐ Nursing H			daughters (Specify)residence
Division	tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 1 ☐ Medical Examiner	ian: To the best of my knor: On the basis of examina and manner stated.	wledge, deatl tion and/or in	h occurred at the til vestigation, in my o	me, date and place pinion, death occu	e, and due to the corred at the time, d	ause(s) and manr ate and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. Licens 5 8	e number	2	9d. Date signed (	Month, Day, Year)
r	7+1C+		30. Name and address of person who comp Jeffery Hoeck	4175 N.Hanson	n Stre		203 - Bow	ie, MD 2	0716	
	Sta Registr		31. Date filed (Mont ADG 113 200	32. Registrar's Signat		have				

DHMH 17 Rev 1/2001

		•	State Registrar					Ce	rtificat	e of	Death	1		Reg. No	2001	2101	J
	Physicia /Medic		1. Decedent's Name	e (First, Midd	le, Last) KENNETH	I A. R	ICKAI	RD, SR					2. Date of De Month	eath 3/19/20	009 Year	3. Time of De 11:35 P	
Aura .	Examin		4a. Facility Name (//		n, give street and no BAY CARE		ΓER		4b. City,			of Death		4c.	County of De	ath CHESTER	
	Funeral Director		5. Social Security N 521-38-6		6. Sex 1 <b>X</b> M 2□ F	7. Age	(In yrs. la:	st birthday) Yrs.	If Unde Months	1 Year Days	If Unde Hours	Min.	8. Date of Bi (Month, D 4/3	rth ay, Year) /1934	9. B	irthplace (State or F Country) MICHIGAN	ore
	TD.		Usual Residence of	Decedent												1	
	ylan		10a. State	10b. County	'		10c. City,	Town or Lo	ocation							10d. Inside City I	
	the Marylan 28a-f show	눥	MARYLAND	DC	RCHESTER					C	CAMBI	RIDGE	3			1 <b>X</b> Yes 2	^
	128%	re	10e. Street and Nur	mber					10f. Zij	Code				10g. Ci	tizen of What (	Country?	
	23a or	al D		2610	BRIAN CIR	CLE					216	13			J	JSA	
980	72 hours after death with the Maryland inatural", or items 23a or 28a-f show offert Examiner must be modified at	by Funeral Director	11. Marital Status  1 Never Marr 3 Widowed		If Yes. G	orces? 2 <b>X</b> ] No Sive	ver in U.S.	- 1	Was Dece If Yes, spe 1 □ Yes		lispanic C an, Mexic Specif		pecify Yes or No Rican, etc.)	0-	14. Race - Ar Black, Wh Specify:	nerican Indian, ite, etc.	
2-0	72 hou	eted	(Spec		nt's Education est grade completed	f)	-	16a, Dece	edent's Usu kind of wo DO NOT u	al Occup ork done	oation during mo	ost of work	king	16b. K	(ind of Busines	s/Industry	
21215-0036	within iene. than "	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5+	-)	lite.			engii				CITY GO	VERNMENT	,
	be filed wit stal Hygien d other th event, the		17. Father's Name	(First, Middle	, Last)		<u> </u>				18. Mot	her's Nam	e (First, Middle	e, Maider	Surname)		
an	ld be lental ked o	To Be			NRY KEMPI	ER RIG	CKARI	D					IDA EN	MILY	RICHMC	ND	
Maryland	s 1 and 2 should be file f Health and Mental H tem 27 Is marked oth other traumatic event		19a. Informant's N		ship (Type. Print) KARD / WIF	<u> </u>		19b. Mail	ing Addres				ral Route Numi				
ā,	f Hear f Hear item		20a. Method of Dis	position			20b. Pla	ace of Disp metery, cre	osition (Na	me of			Date	20c. L	ocation - City	or Town, State	
Baltimore	0		1 □ Burial 2 4 □ Donation		3 ☐ Removal from Specify)	n State	1	metery, cre HORE C	-			08/2	1/2009		CAMBI	RIDGE, MD	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Fu	unard Service	Licensee			'	2. Name a JRRAN-I			•	L HOME, P.A	, 308 F	HGH ST. C/	MBRIDGE, MD	21

Examiner

Physician/Medical

Medical Certification: To Be Completed by

**Physician** 

/Medical

the burial-tran

**Examiner** 

or Attending Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

of Vital Records.

Division

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neral Director: A
filled in by the fu

within 24 hours a

To the Funeral I

completely filled

### HENRY KEMPER RICKARD

23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line chronic

CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Due to (or as a conse - nce of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy

5 Other (specify)

23d. Date of delivery

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No

sea se 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death 1 Natural
2 Accident 5 Pending

investigation 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 8/21/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) atricia

100 Bramble

31. Date filed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registra AMEND#26perMD, 8-14-09, BMW.MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08 Month 2009 Mae Leah Siegel 4:20A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 03/05/1918 Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) Months 1 □ M 🛪 🕏 F 577-50-4639 91 PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1. Yes 2 No MD Gaithersburg Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9890 Washingtonian Blvd. 20878 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates Specify. Specify:White 3 ₩idowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Nursing Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Benjamin Barezofsky Bertha Blendman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Siegel - Son 8334 Tilly Mill Lane, Indianapolis, IN 46278 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt.Lebanon Cemetery 08/07/2009 Adelphi, MD 22. Name and Address of Facilit Danzansky-Goldberg Memorial Chapels 21. Signature of Funeral Silvic Lio See M01163 1170 Rockvile Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PHEUMONIA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury) Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

23a or

Director

Funeral

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Completed

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Modical Explainer is ust be notified at

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7 Is marked other th

Pages 1 and 2 ment of Health a

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3altimore, Maryland 21215-0036

Examiner Physician/Medical ò

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Certification:

Medical

physician and the burial-transit attending p signed by the aid be detached for should Completed cate has page 2 s

The law requires that the death certificate be executed

Box 68760.

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Division of Vital Records,

Physician: this certific

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death. after death Director d in by the f

within 24 hours a Hospital

certificate

After thi funeral of

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 27. Manner of Death Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number 20061096 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOLLAPALLI 6121 MONTROSE ROAD ROCKVILLE, MD 20852 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Albert William Smith 2009 2:24 P M August 18 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 20359 Leitersburg Pike Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/25/1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 1 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours 90 216-14-6535 MD Director Usual Besidence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2 X No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any finury or other traument." 21742 US 20359 Leitersburg Pike Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. White Specify: Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lottie Mae Eckard Simon L. Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard E. Smith / Son 3912 Albert Avenue, Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery | 08/22/2009 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Euneral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 4 PANS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions Due to for as a consequence off Examiner n any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 1 Ves 2 No 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 TUBERCULVSIS 1 Yes INFECTION 2 No 3 Probably 4 Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

the death certificate be executed P.O. Box 68760. or Vital Records, Division

burial-trai

r 28a-f show notified at

a or

peen page 2 s has certificate or Attending Physician: this eral Director: After filled in by the funer death. within 24 hours a

5H-15

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

Medical

29a, Certifier

29b. Signature

(Check only one)

**AUG 19** 

daddress of person who completed cause of death (Item 23a) (Type, Print)

title of certifie



**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner	48
Funeral	5.

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modeal Evantment once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 15+1 Registra

	For State Registrar			-		rtificate of			R	eg. No	2000	9 2	7685
an	1. Decedent's Name  Janet	,	<sub>Last)</sub> Spurrier					. 1	Date of Dead Month Lgust		y 2009 <sup>Year</sup>		ime of Death
al er			give street and number)			4b. City, Town, o	or Location of Dea		gust	_	County of Dea		7.30 р
<b>61</b>	411 Dela		-			Freder				F	rederic	k	
	5. Social Security No. 219-46-2 Usual Residence of	136		e (In yrs. last birt 61	hday) rs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	1. (/	Date of Birth Month, Day V 28,	Year)	9. Bii 47 Mar	rthplace (Sountry) yland	State or Foreign
	10a. State	10b. County		10c. City, Town	or Lo	cation						10d. Ins	ide City Limits
ţċ	Maryland	Freder	ick	Frederi	.ck							11	Yes 2 □ No
al Direc	10e. Street and Num		ad			10f. Zip Code 21701	•			0g. Cit USA	izen of What C	ountry?	
Be Completed by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Decedent Armed Forces? d 1 Tyes 2 1 If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub l □Yes 2☑No	Hispanic Origin? an, Mexican, Pue Specify:	(Specify \ erto Ricar	Yes or No- n, etc.)		14. Race - Am Black, Whi Specify:	te, etc.	ian,
mpletec	(Speci		Education grade completed) College (1-4or 5	+)	(Give life. l	dent's Usual Occu kind of work done DO NOT use retire	during most of w d)		b	16b. K	ind of Business		
ပ္ပ	12 17. Father's Name (		pet)	Re-	·ınv	/estment	supervis 18. Mother's Na		st Middle i	Maiden	A T & !	Ι΄	
Be			Ray Spurrie	r			France	•		viaiueri	Surrame)		
오	19a. Informant's Na	me/Relationship	(Type. Print)	19b.		ng Address (Street			rpers	Fer	ry, We	st Vi	rginia
	20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☐ Donation	Cremation 3	☐ Removal from State			sition (Name of natory or other pla		Date 18-20			254; ocation - City of lerick,		
	21. Signature of Full			21	_	. Name and Addre					eral Hor		
_	Maro	n Ca	nulle G	line		521 Oposs					ick, Mar	-	
/	a. Fart1. Enter the shock, or hear limmediate Cause (disease or condition resulting in death)	Final	omplications that caused have one cause on each line.	I the death. Do note.	و و ٥	-	ng, such as cardi	ac or res	spiratory arr	est,		Interv	eximate rat Between tand Death
er	Sequentially list con	ditions,	b	a consequence o								-	
amin	Sequentially list con cause. Enter Under Cause (Disease or that initiated events		с										
edical Examiner	resulting in death) L	ast	Due to (or as	a consequence o	f):								
Medi	IF FEMALE:									-1			
Be Completed by Physician/M	23b. Was decedent in the past 12 r 1  Yes 2 1 9  Unknown	months? ₩o	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death		Ectopic pregnand Other (specify) _	су				23d. Date of de Month	elivery Day	Year
by Pr	Part II. Other signifi	cant condition	scontributing to death be		the ur	nderlying cause giv	ven in Part I.				use contribute t		
ted	$-\frac{OI}{II}$	مو للو	1	ell, tu	7			-	1 □ Y	es 2	<b>(257)</b> ∘ 3 □ F	robably	4 Unknown
Comple	- Hu	11 en	1, en vier					-	24a. Was a autops perfori 1 □Yes		prior to	completion	dings available on of cause of lo
Be	25. Was case referrexaminer?		Hospital:			t all DOA Oth	26. Place of D		` -				
은	1 Yes 2 27. Manner of Death		1 ☐ Inpatie	nt 2 ER/Out	<u> </u>	IL SLI DOA	4 Li Nursing				6 ☐Other (Sp.	ecify)	
tio	1 Natural 2 Accident	5 Pending investigat	(Month, Day	y, Year) Ir	ijury	Wor	k? lYes 2 ⊟No	2.00.	Describe III	ow mju	ry document		
ertifica	3 Suicide 4 Homicide	6 Could no determin		ury - At home, far c. <i>(Specify)</i>	m, stre	eet, factory, office			ocation (S. City or Tow		nd Number or F e)	Rural Rout	e Number,
Medical Certification: To	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	f examination and	, deati	n occurred at the tivestigation, in my	ime, date and pla opinion, death oc	ce, and o	due to the o	cause(s late an	s) and manner a d place, and du	as stated. ie to the ca	ause(s)
Me	29b. Signature and	litle of certifier				29c. Licens	Se number	\	2	9d. Da	te signed (Mon	oth, Day, Y	éar)
	1-1-	A	completed cause of d	eath (Item 23a) (	Type,		C4:	Ī	•••	0.1	- £ ~-	Lon	chun
e	31. Date filed (Monta	h, Day, Year) AUG 1	32. Registri	ar's Signature	À	Sparked	Lorin	Wr	مس	YIK	o rie	V.60.	इं। र्
1				1		Theresales							

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death

			Registrar		Cer	lineale of	Dealli	Re	eg. No.	
	Physici	an	Decedent's Name (First, Middle, Last)	1 .				2. Date of Deat Month August	h Day Year	3. Time of Death
	/Medic			lari			- Land David	August		3:35 P. M
	Examin	er	4a. Facility Name (If not institution, give street 16401 Lea Drive	and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
н	Director		579-62-9845 XXM		Yrs.	Months Days	Hours Min.	May 20,		ountry) shington D.C.
	P .		Usual Residence of Decedent							
	ıryları show	_	10a. State 10b. County		City, Town or Loc	cation				10d. Inside City Limits 1 □Yes 2 🕅 No
	Ba-f s	Sch	Maryland Prince Geo	rge's Bo	wie 					
	vith th	Ë	10e. Street and Number			10f. Zip Code 2071	_		0g. Citizen of What Ci	ountry?
	s 235	eral	16401 Lea Drive	lee Decedent From it	-110 112 W				14. Race - Am	orican Indian
	item irer	Funeral Director	11. Marital Status 12. W A 1 □ Never Married 2 Married 1.	as Decedent Ever i med Forces? K∐Yes 2 ☐ No	11 U.S. 15. V	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the fredical Exercite round be redified at once.	by	3 ☐ Widowed 4 ☐ Divorced	Yes, Give ar or Dates: 7/1	968-6/19 <sup>1</sup>	72 Yes 2 No	Specify:		Specify: Wh	nite
0-0	2 hou	Completed	15. Decedent's Education	inloted)	16a. Deced	lent's Usual Occup	pation	ina	16b. Kind of Business	/Industry
21	thin 7 se. an "r	nple	(Specify only highest grade com Elementary/Secondary (0-12) C	ollege (1-4or 5+)			during most of work d)		Law	
2	ed wi ygier ygier t, the	ပ္ပ		2	Polic	e Office			Enforcemen	nt
nd	be fill Ital H Id oth	Be	17. Father's Name (First, Middle, Last)	•			18. Mother's Nam			
Ye	ould I Mer narke	ပ္	Joseph Vincent Solar							
Mai	32sh shang 7 Isn traun		19a. Informant's Name/Relationship (Type. P. Maryann E. Solari/Wi	,			and Number of Hui ve, Bowie		; City or Town, State, and 20715	ZIP Code)
	1 and Healt em 2		20a. Method of Disposition		b. Place of Dispos cemetery, crem				20c. Location - City or	r Town, State
0	ages ent of t: If it		1X Burial 2 ☐ Cremation 3 ☐ Remov	ai from State	cemetery, cremary land					e, Maryland
Baltimore,	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	111					Evans Fune	
Ba	permi Depar Impor any ir		Jan P. Kning						, Maryland	
			23a. Part 1. Enter the disease, or complication	rs that caused the d					not .	Approximate  Approximate  Approximate
	Physician		shock, or heart failure. List only one call	12511	0- C/SC	JUNA	19 ML	LANC	th	nset and platil
	/Medical		disease or condition resulting in death)	ue to (or as a con	sequence of):			0.4		0 1
	Examiner		Sequentially list conditions b	1						
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a con	sequence of):					
	ecute and trans	(am	Cause (Disease or injury that initiated events c resulting in death) Last	D						
60,	be ex ician ourial		residing in assault East	Due to (or as a con	sequence or):					
68760,	Attending Physician: The law requires that the death certificate be executed r death.  cetor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	an/Medical	d							
ox 6	th certifica tending pl r use as tl	/Me	IF FEMALE: 23c. If	yes, outcome of pre	egnancy			_	23d. Date of de	alivery
$\mathbf{\alpha}$	seath atter	ciar	in the past 12 months?	Live birth 2 F	etal death 3	Ectopic pregnand Other (specify) _	СУ		Month	Day Year
0	at the deatl by the atte	Physicia	9 Unknown	Unknown						
œ.	s that med t	by PI	Part II. Other significant conditions contribute	ing to death but not	resulting in the un	derlying cause giv	en in Part I.	23e. Did tot	bacco use contribute t	to the cause of death?
ğ	v requires been sign should be	pg p						1 □ Y€	es 2⊠No 3⊟F	Probably 4 Unknown
သွ	aw re	Completed						24a. Was a	n 24b. Were a	autopsy findings available completion of cause of
Ä	r: The law icate has b	E	_	_				autops perforr 1 🗆 Yes 2	med? death?	_
ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat			
of Vital Records,	hysic his ce I dire	10	1 ☐ Yes 2 No Hospit	1 L Inpatient	2 ER/Outpatien	t 3 □ DOA Oth	ner: 4 \sum Nursing Ho	ome 5 Reside	ence 6 ☐ Other (Sp	ecify)
2	ding Ph h. After th funeral	 0	27. Manner of Death 1 Death 5 □ Pending	<ul> <li>a. Date of Injury (Month, Day, Yea</li> </ul>	r) 28b. Time of Injury	Wor		28d. Describe ho	ow injury occurred	
sio	r Attendl er death. rector: A	cati	2 Accident investigation				Yes 2□No			
Division	or Att after d Direct d in by	Certification:	4 Homicide determined	e. Place of Injury - A building, etc. (Sp	At home, farm, stre necify)	eet, factory, office		City or Town	treet and Number or F n, State)	Rural Houte Number,
	pital Durs a eral I		29a. Certifier 1 Certifying Physicial	To the kest of my	knowledge death	occurred at the t	ime date and place	and due to the o	cause(s) and manner	as stated.
	24 hd Fun etely	Medical	(Check only 2 Medical Examiner:	On the basis of exar	nination and/or inv	vestigation, in my	opinion, death occur	rred at the time, d	late and place, and du	ue to the cause(s)
	To the Hospital or I within 24 hours after To the Funeral Direction Completely filled in b	Me	29b. Signature and title of certifier			29c. Licens	se number	2	94-Date signed (Mor	oth Day Year)
			1/1/1/1/1/1/			000	30149		D-4-1	01
J	المد		30. Name and address of person who comple	ted cause of death (	(Item 23a) (Type, F	Print)	0-11			4
C	Mati		Hector Dilva, M.	D 751	05 001	ER DRI	ve Ste. ?	502 TO	IM, mewo	21204
	Sta		31. Date filed (Month, Day, Year) AUG 12 2009	32. Registrar's S	ignature	and				
	Registr	ar	AUG 1 & ZUUS	Denne	B. 4	W.				

State of Maryland / Department of Health and Mental Hygiene

	_	For State Registrar		Cer	tificate of	Death		g. No. 2009	27687
Physicia		Decedent's Name (First, Middle, La  William	Walter	Samps	on		2. Date of Death Month	23, 2009 Year	3. Time of Death 5:15am M
/Medica Examine		4a. Facility Name (If not institution, given the second of	ve street and number)	Sampa	4b. City, Town, o	r Location of Death		4c. County of Death	
Funeral Director		213-32-0022	Sex 7. Age (In y. 11	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 2,	Year) 9. Birth	place (State or Foreign ntry) MD
e Maryland 3a-f show tiffed at	Director	Usual Residence of Decedent  10a. State  MD  Alle	gany 10c.	City, Town or Lo	nberland				10d. Inside City Limits 1 □ xes 2 □ No
with th		10e. Street and Number  941 Winifred Ro	oad		10f. Zip Code	21502	10	g. Citizen of What Cou USA	
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a five firminer must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Vas Decedent of H fYes, specify Cub □ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Bican, etc.)	14. Race - Amer Black, White, Specify:	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene. portant: if item 27 is marked other than "natural", or y injury or other traumatic event, it all witer Exmit	Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life, L	dent's Usual Occup kind of work done DO NOT use retired trician	pation during most of work d)	sing 1	6b. Kind of Business/Ir	ndustry
/land /	To Be C	17. Father's Name (First, Middle, Last Edward Sam	,			Cathe		lker Samps	
Mary nd 2 sho alth and 1 27 Is me r traume		19a. Informant's Name/Relationship Agnes Sampso		19b. Mailir 94	g Address <i>(Street</i> 1 <b>Winifre</b>	and Number or Rued Road	ral Route Number, Cum	City or Town, State, Zinberland	MD 21502
limore, Pages 1 a tment of He tant: If item jury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ ★ ination 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	⊒ Hemoyai Irom State   (	Scarpelli F	sition (Name of natory or other plan uneral Hom	ne, P.A.	8/24/2009	Cresapto	
Baltime permit. Pag Department Important: In any injury o		21. Signature of Funeral Service Lice	nsee	22	Name and Addre Scarp 108 V	sellî Facility 'irginia Avenu	lome, PA ie: Cumberla	nd, MD 21502	
Physician /Medical		23a. Party Enter the disease, proof shock, or heart/ailure. List/only Immediate Cause (Final disease or condition resulting in death)	nplications that daused the decone cause on each line.  a.  Due to (or as a cons	schene		ng, such as cardiac		sst,	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):					
68760, ificate be executed g physician and its the burial-transit	Medical Exar	that initiated events ' resulting in death) Last	Due to (or as a cons	equence of):					
entifi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1  Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3 ☐	Ectopic pregnand Other <i>(specify)</i>	ey .		23d. Date of deli Month	very Day Year
cords, P w requires that been signed b should be deta	ል	Part II. Other significant conditions	-	resulting in the u	nderlying cause giv	ven in Part I.		acco use contribute to s 2 ☐ No 3 ☐ Pro	
Vital Reco	Completed		ŕ				24a. Was ar autops perforn 1 ∐Yes 2	y prior to o ned? death?	opsy findings available ompletion of cause of
Vita ysician s certifii	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2.☐ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Oth	nor:	th <i>(Check only one</i>	e) ence 6 □Other <i>(Spe</i> o	ify)
Division of Vital Records, lor Attending Physician: The law requires t after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be or a fine by the funeral director.	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Inju Wor M 1		28d. Describe ho	w injury occurred reet and Number or Ru	
Div Hospital or A 24 hours after Funeral Direc		4 ☐ Homicide determined	building, etc. (Spe	ecify)			City or Town	n, State)	
Div To the Hospital or within 24 hours after To the Funeral Dire completely filled in It	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, deat hination and/or in	n occurred at the t vestigation, in my	opinion, death occu	e, and due to the corred at the time, d	ause(s) and manner as ate and place, and due	to the cause(s)
To To To To To To To To To To To To To T	≥ .	29b. Signature and title of continue	hysician: To the best of my miner: On the basis of exame and manner stated.  Completed cause of death (1) (1) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4		29c. Licens	001756	5	9d. Date signed (Month	1, 200 9
		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)	L2 U21	~ 70	2150	
Stat Registra		31. Date filed (Month, Day, Year)	8 2009 Lenew	gnature A.	Ball				

			_ FOF	partment of Health and Nertificate of Death		ene g. No 2009	27688
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Aug. 12		3. Time of Death 9:30p M
No.	/Medic	al	Phillip L. Taylor  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-	Funeral		Wilson Health Care  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda	Gaithersburg  J If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgome 9. Birthp	place (State or Foreign
L	Director		189-20-6068 1 ★M 2□ F 81 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8 /20 /19	927 Broo	Ekton, MA.
	iryland show	_	10a. State 10b. County 10c. City, Town or	ocation ersburg		1	Od. Inside City Limits
	the Ma	recto	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	1 ☐¥es 2 ☐ No
	ath with	<b>Funeral Director</b>	333 Russell Avenue # 611	20877		USA	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	b	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13∑ Yes 2 □ No 1945  If Yes, Give Year or Dates:	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ <b>X</b> No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: W	
21215-0036	in 72 ho	Completed	(Specify only highest grade completed) (Gi	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	ing 1	6b. Kind of Business/In-	dustry
1212	led with lygiene. her thai	Com	College (1-4or 5+) 5 +	Broker		Business	
land	uld be filed Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last) Howard Taylor	Heler	e (First, Middle, Mi n Field		
, Mary	and 2 should   ealth and Men n 27 is marke ner traumatic	-		iling Address (Street and Number or Rui ! East Forest Pe			
Baltimore, Maryland	es 1 of H if iter		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Remotival from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Discemetery, circles a point of the Saperation	ematory or other place)		oc. Location - City or To Beltsville	•
Ball	permit. Pag Department Important: I any Injury c		21. Signaturi Viruneral Service License	PHYTTPPADSRINALD 9241 Columbia B	FUNERA Lvd.Silv	AL SERVICE ver Sprin	E,P.A. g,Md20910
and.	Physician	7 7	23a. Part 1. Enter the disease, or complications that caused the death. Do not established, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition metastatic	nter the mode of dying, such as cardiac	or respiratory arres	1	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		===		
)	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
o,	icate be executed physician and the burial-transit	Examiner	resulting in death) Last  C				
58760,	ficate by physici s the bu	edical	d				
O. Box (	the death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Me		B ☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive	ery Day Year
rds, P.	The law requires that the do are been signed by the bage 2 should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to to	
Vital Records,	The lar ate has page 2	Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to co	psy findings available mpletion of cause of 2 No
1 VII		To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other:	th <i>(Check only one</i> ome 5 ☐ Resider	) nce 6 ☐ Other (Specia	
on ot	ding PI h. After th funeral	tion:	27. Manuer of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation		28d. Describe hov	v injury occurred	
Division	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	ne Hospit n 24 hours ne Funera pletely fille	Medical (	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due to	stated. o the cause(s)
	T P P P P P P P P P P P P P P P P P P P	Ž	29b. Signature and title of catalog.	29c. License number	29	d. Date signed (Month, August 13	2009
	`		30. Name and audress of person who completed cause of death (Item 23a) (Typ	911 Russell A	tue. G	izuthersbu	g md.
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 14 2009  33 Registrar's Signature	well			

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		artment of Hi rtificate of L			eg. No. 🤈 🎧	no	27689
	Physici		1. Decedent's Name (First, Middle, Lateral Bessie Marie	Tress				2. Date of Deat Month August	Day	Year 009	3. Time of Death
'a	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County		1100
<i>)</i>	Funeral	C I	Washington Cour 5. Social Security Number 6. S	ex 7. Age (In yrs.		Hage If Under 1 Year Months Days	erstown If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 29,	Year)	9. Birthp Coun	
No.	Director		232-50-8269	<sup>1</sup> 2 AF 77	Yrs.			Sept.29,	1931	West	Virginia
	ryland how	L	Usual Residence of Decedent  10a. State 10b. County  West	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	e Ma 3a-f s tiffed	cto		eley		Falling V	Vaters				
	ith the	Director	10e. Street and Number	-		10f. Zip Code		11	0g. Citizen of V	/hat Coun	try?
	s 23a	rai	72 Chariot Lane	12. Was Decedent Ever in U	0 140		25419	ooify Voo or No	14 Bace	USA - America	an Indian,
20	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2[7] Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		k, White,	
ξ	thou satura	pa	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu		
0	nin 72 in "na Medio	plet	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired,	luring most of work }	ing			
7	d with	Completed	12			Homemak				Home	
2	w = 0 %	Be (	17. Father's Name (First, Middle, Last				18. Mother's Name			e)	
Уľа	ould be Mental arked o	2	William Helm					Otis Pol			
Maryland 21215-0036	and raum		19a. Informant's Name/Relationship (			ng Address (Street a					
	1 and Health		Donald Tress-Hus 20a. Method of Disposition		72 C	Chariot La	<u>ne Falli</u>		s, West 20c. Location -		ginia 25419 wn State
more,	Pages nent of It ant: If Ite		1X Burial 2 ☐ Cremation 3 ☐	JHemovai from State		osition (Name of matory or other place	1			•	
	it. Partmenturtant	1	4 □ Donation 5 □ Other (Special 21. Single of Tuner 5 or Vice Lice			e Memorial P Sboyne <sup>Ad</sup> Te				e, M	aryland
ם מ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ex once.	1	1150							ort.	MD 21795
		t	23a Part1 Enter the disease, or com	plications that caused the deat						OL C /	Approximate Interval Between
l.	Physician /Medical Examiner		Inmediate Cause (Final disease or condition resulting in death)	aDue to (or as a conseq	quence of):	of Aust	a Ane	rsym	27-8-	7	Onset and Death
	R	Jer	Sequentially list conditions, it is a sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	uence of c						
	cuted	Examiner	that initiated events	c							
00/00	ficate be executed physician and is the burial-transit	cal Ex	resulting in death) Last	Due to (or as a conseq	quence of):						
		ledical									
P.O. DOX	The law requires that the death certing the has been signed by the attending tage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)				e of delive	ery Day Year
	that ned by detax		Part II. Other significant conditions					23e. Did tol	bacco use cont	ribute to t	he cause of death?
2	quires n sigr ald be	d by	Hypertension	Atheroschler	stee :	renel cub	ery and	1 □ Y	es 2□No	3 Prob	bably 4 □Unknown
vital Records,	The law rec te has bee age 2 shou	Completed	Viscend c	-tery disease	1 Hy	percholes	rivlemia	24a. Was a autops perform	med2		opsy findings available impletion of cause of
g	lan: rtifica xtor, p	BeC	25. Was case referred to medical				26. Place of Dea		-	55	
> _	Attending Physician: r death. ector: After this certifics by the funeral director, p	To B	examiner? 1 XYes 2 No	Hospital: 1 npatient 2	ER/Outpatie	nt 3□ DOA Othe	er: 4 🗆 Nursing He	ome 5 ☐ Reside	ence 6 □Oth	er (Specil	(y)
DIVISION OF	ng Pl		27. Manner of Death  1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Work	y at k?	28d. Describe ho	ow injury occur	red	
2	tendi eath. tor: A	Certification:	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □ No				
2	or At fiter d Direct in by	ij	4 Homicide determined	28e. Place of injury - At h building, etc. (Speci		reet, factory, office		28f. Location (S: City or Town		er or Hura	al Route Number,
7	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce		hysician: To the best of my kno miner: On the basis of examination							
	ormple	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signe	d (Month,	Day, Year)
	F ≤ F ŏ		+ 60 Popular Zu	~		038	764		*/101	CIE	
,			30. Name and address of person who	completed cause of death (Iter	m 23a) (Type,	Brint)	•		3/17/	(L)	
ثك	H-5		KARL P. RIVELE	MID. ISIIO	Meden	و دسوس	Re She	127	Heger	رسداء	~ WV 5131
	Sta Regist		31. Date filed (Month, Day, Year)  AUG 18	32. Hegistrar's Sign	ature	how			-		

DHMH 17 Rev 1/2001

Certificate of Death

3. Time of Death

8:30P

9. Birthplace (State or Foreign

NEWPORT NEWS.VA

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

1 XYes 2 No

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

State Registrar 30. Name and address of person

ESMERANDO O.JUANITEZ

DHMH 17 Rev 1/2001

1160 VARNUM STREET NE #008 WASHINGTON, DC 20017

			1- For Amend Item 23 Registrar	e State of M	arylan • <b>889</b> 5	d, 69729 Cer	yogan of l	lealth <i>Death</i>	and Me	ental Hyg R	iene	2009	27691
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Deat		. Year	3. Time of Death
	Physicia /Medic		MARY	Т.		THOMPS	ON		1	4ugust		1 2009	9:55 AM
	Examin		4a. Facility Name (If not institution, giv	,	)		4b. City, Town, o		of Death		4c. (	County of Death	
			PRINCE GEORGE HOS  5. Social Security Number 6. S		ne (In ure	ast birthday)	CHEVERL If Under 1 Year		24 Hrs. [ g	8. Date of Birth		INCE GEO	RGE lace (State or Foreign
	Funeral Director				70	Yrs.	Months Days	Hours		1-08-19	39°	MARYL	
			Usual Residence of Decedent										Od Incide City Limite
	arylar show	7	10a. State 10b. County		10c. City	y, Town or Lo	cation					1,	0d. Inside City Limits  1√2 Yes 2 No
	the M	Director	MD PRINCE G	EORGE	LAND	OVER_	10f. Zip Code			1	0a. Citiz	en of What Coun	Λ.
	3a or		1511 WARREN AVEN	HE			20785				-9.	U.S.A.	•
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Middel Even in the prefilled in	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13. V	Vas Decedent of I f Yes, specify Cub	Hispanic Or	rigin? (Spec	eify Yes or No-	1	4. Race - Americ Black, White, e	
36	or ite		1 Never Married 2 Married	1 ∐Yes 2 🔀 If Yes, Give			Yes 2 □ No	Specify		icari, ctc.)		Specify: BLAC	
1215-0036	hours hural"	ed by	3 ₩ Widowed 4 □ Divorced	Year or Dates:			ient's Usual Occu	nation		1		d of Business/Inc	
5	iin 72 in "na"	plet	15. Decedent's Ed (Specify only highest gra	de completed)	5.1	(Give . life. L	kind of work done DO NOT use retire	during mos d)	-			JERNMENT	addit y
212	d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	FOO	D SERVIC	E MAN	AGEME	NT	GOV	LENNTENT	
g	d d o	Be	17. Father's Name (First, Middle, Last)					18. Moth	er's Name (	(First, Middle, I	Maiden S	Surname)	
<u>\{ \} \</u>	d 2 should be th and Menta 7 is marked traumatic ev	မ	JOSEPH A. HARRISO			101 11 11				A. FRAN			0-4-)
<u>8</u>	12s har 7is trau		19a. Informant's Name/Relationship ( STEPHANIE BROWN/D.			1	g Address <i>(Stree</i> 87 <b>th AV</b> E						(0000)
ē,	es 1 and 2 of Health item 27 i		20a. Method of Disposition		1 0	lace of Dispos	sition (Name of natory or other pla		Da			ation - City or To	wn, State
Ē	0		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			-	NATION.	i i	8-21-2	2009 s	UITI	AND, MD	
Baltimore, Maryland 2	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	see	0		. Name and Addre			ENKINS	FUNE	ERAL HOM	Е
	<u>0</u> 0 = @ 0	Ш	1. D. M.	-hal	<u> </u>		74 LANDO					20785	Approximate
			23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each l	ine.		LUNG			respiratory arr	est,		Approximate Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	a. METK			LUNG	CAN	CEN				
	Examiner			Due to (or as	a consequ	terice oi).							
	D ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5ua to (or as	a consessit	ianea of)r							
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
3/60,	certificate be executed rding physician and ise as the burial-transit	a E	Tooling in doday East	Due to (or as	a consequ	ience or):							
/89	ficate phys s the	edical		d									
XOR	leath certifica attending ph for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1e				2	3d. Date of delive	ery
в	ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 👿 No	1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown			Ectopic pregnan Other (specify) _	СУ			İ	Month	Day Year
7. O	w requires that the de been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant conditions of		nut nat race	ulting in the cur	dorlying payes gi	on in Port	1	23a Did to	hacco us	se contribute to the	ne cause of death?
g D	signe		CONGESTIVE HE		LURE		idenying cause gi	ven in Fait	1.	ر ا	<del>-s-</del> 2 <b>)</b>		pably 4 Unknown
ecords,	law requas been 2 shoul	Completed by	THROMBOCYTOFENIA	<del></del>						24a. Was a			psy findings available
Υ	ician: The lav certificate has rector, page 2.9	ошо	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>						autops perfori	med?	prior to co death?	mpletion of cause of
VITal	lan; T	Be C	25. Was case referred to medical					26. Plac	e of Death	1 □ Yes (Check only or	2 No ne)	1 ☐ Yes	ZLINO
01 <	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpat	ent 2	ER/Outpatien	t 3 □ DOA Ot	ner: 4□N	lursing Hom	e 5 Resid	ence 6	□Other (Specit	5/)
Ĕ	ing P	ion:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, Da	ury a <i>y, Year)</i>	28b. Time of Injury	Wo			8d. Describe h	ow injury	occurred	
UIVISION	death death stor: /	ertification:	2 Accident investigation 3 Suicide 6 Could not be		iury - At ho	me farm str	M 1 Deet, factory, office	Yes 2		Rf Location (S	traat an	d Number or Rura	al Route Number
	al or A after Direction by	ertii	4 Homicide determined	building, e	c. (Specif	y) (14111, 611	sot, labiory, office			City or Tow		Transfer of rion	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to	calC		ysician: To the best niner: On the basis									
	the H hin 24 the Fi	<b>l</b> edical	one)	and manner s		tion and/or in							
	5 7 vit	Σ	29b. Signature and title of certifier		AND THE RESERVE THE PARTY OF TH		29c. Licen		14			e signed (Month,	
•		ż	30. Name and a less of person who	completed cause of	death (Item	23a) (Tune	Print) -	العوار	4		MU	o. 15	-001
12	_ 10		A. MAHALINGKSI			300	HOSPI	ML	DR	CH	EVE	RLY, M	2009
	Sta		31. Date filed (Month, Day, Year) AUG 1 7 2009	32. Regist		ture				-		, –	
	Registr	ar	HUG 1 1 2003 /	Enera > B	. 19	service							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. ? () ()

			For State	State of Maryland / D	-	ent of Hea ate of De			000	0 07600
			Registrar     Decedent's Name (First, Middle, Last)		OCITING	ale or be		Reg. 2. Date of Death		3. Time of Death
	Physici /Medio		Ruth	Ann		Thiess	l	HOUST	Day Year 19 200	9 1427 PM
To day.	Examir		4a. Facility Name (If not institution, give s	· · · · · · · · · · · · · · · · · · ·		City, Town, or Loc		1	4c. County of Dea	
-	Francis	-	Washington County 5. Social Security Number 6. Sex	7. Age (In vrs. last bir		Hagersto		8. Date of Birth	Washin	rthplace (State or Foreign
	Funeral Director		213-32-6686	M 0 10 -	Yrs. Mor	ths Days H	ours Min.	(Month, Day, Ye	ear) C	ountry) ryland
	put M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits
	Maryla f sho	ō								1 ☐ Yes 2 No
	<b>r 28a</b> -	Director	MD Washingt  10e. Street and Number	on Hagers		. Zip Code		10g.	Citizen of What C	ountry?
	th with	ai D	13535 Cherry Tree	Circle		21740			U.S.A	
	be filed within 72 hours after death with the Maryland rial Hygiene. ed other than "natural", or items 23a or 28a-f show event, I'm Madral Even has I have beent, I'm Madral Even has I have beent, I'm Madral Even has I have been the second of the second of the second of the second of the manufacture of the second of the sec	Funeral	11. Mariar States	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was D If Yes,	ecedent of Hispa specify Cuban, N	nic Origin? (Spec lexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	I", or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 <u>□</u> Yes 2 <u>[A]</u> No If Yes, Give Year or Dates:	1 □ Ye	s 2KNo S	pecify:		Specify: W	hite
5-0036	2 hou		15. Decedent's Educ		Decedent's	Usual Occupatior f work done durin	n mast of workin	161	o. Kind of Business	s/Industry
2121	within 7 liene. • than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired)	g most of working			
d 2.	filed w Hygie other ti		17. Father's Name (First, Middle, Last)	2 RN		18.	Mother's Name	(First, Middle, Mai	Medical  den Surname)	
lan	should be fand Mental s marked o	To Be	Andrew Holfman				Sally Ta		,	
Maryland		-	19a. Informant's Name/Relationship (Typ	' I	. Mailing Ado				ity or Town, State,	Zip Code)
Σ,			Robert E. Thiess/H						rstown, l	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval nom State		(Name of or other place)	-		c. Location - City o	r Town, State
Ħ	nit. Pa artmel ortant Injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			Cemetery e and Address of	8/22/		agerstow Funeral (	and the same of th
Ba	Depa Impo any Ir		> SMm/ C						rstown, l	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do recause on each line.						Approximate Interval Between
	Physician	9	Immediate Cause (Final disease or condition			ardid		ction		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of): /		0			
in.	M 1	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ducito (or as a sonsequence o	of):					
	cuted nd ransit	Examiner	that initiated events c.							
90,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence of	of):					
68760,	rificate be executed physician and is the burial-transit	edical	d.							
			IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy					23d. Date of de	elivery
œ.	death cer le attendin le for use a	Physician/M	in the past 12 months? 1 □Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death		oic pregnancy r <i>(specify)</i>			Month	Day Year
P.0	w requires that the d been signed by the should be detached	Phys	9 Unknown	9 ☐ Unknown				I		
Ś,	signer	þ	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlyi	ng cause given in	Part I.	23e. Did tobac		to the cause of death?  Probably 4 □ Unknown
COL	v requ been should	Completed	- Renew 1	ej acca				24a. Was an		
Re	e la has e 2	dwc						autopsy performed	prior to death?	
	ician: In certificate ector, pag	Be C	25. Was case referred to medical			26.	Place of Death	1 ☐ Yes 2 ☑ (Check only one)	TNo 1 □ Ye	s 2 No
> 2	Pnysician: r this certific ral director,	70 E	examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3		I ☐ Nursing Hom	ne 5 Residenc	e 6 □Other <i>(Sp</i>	ecify)
UC .	After After funera	jon:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending		Time of njury M	28c. Injury at Work?		8d. Describe how i	njury occurred	
Division	or Attendi after death. Director: A I in by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far			2 No	8f. Location /Stree	t and Number or F	Rural Route Number,
<u>S</u>	safter s after al Dire ed in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		,		City or Town, S		,
:	To the hospital or Attending Prystican; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying Physical Certifying Physical Examination	cian: To the best of my knowledge er: On the basis of examination and and manner stated.	e, death occu d/or investiga	rred at the time, o	date and place, a on, death occurre	and due to the caused at the time, date	se(s) and manner and place, and du	as stat <i>e</i> d. le to the cause(s)
:	vithin To the comp.	Me	29b. Signature and title of certifier			29c. License nur		29d.	Date signed (Mor	th, Day, Year)
			) Jhe	o ful		D21C		· '	8/20/00	7
			30. Name and address of person who con		(Type, Print)	till Aus	E. HAC.	FRSTON	MID 9	4747
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Co. C. Lake	111		Y Vian	. ( [

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6:45 am Physician August 12 2009 Armand I. Vallieres /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min 1**⊠** M 2□ F Massachusetts 577-24-9995 February 23,1922 Director 87 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural". 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2KINo Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 U.S.A. 3118 Gracefield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates:1942-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify by 3 N Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CIA Intelligence Officer 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Grace Lajole Joseph Isidore Vallieres 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6301 Potomac Avenue, Alexandria, Virginia 22307 Joseph I. Vallieres - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08/18/2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 22. Name and Address of Facility Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final Physician disease or condition resulting in death) Cerebrovascular Accident (Stroke) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Jse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9□Unknown 9 I Unknown signed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus has page 2 autopsy performe certificate 2 🔀 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 🛣 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 1 🖾 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. Hospital or Attending

24 hours after death • Funeral Director: To the Within

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Izuchukwu Obi, M.D., 7300 Van Dusen Road, Laurel, Maryland 20707 31. Date filed (Month, Day, Year)

and manner stated.

State Registrar

**AUG 14** 

determined

4 ☐ Homicide

29b. Signature and title of certifier

29a. Certifier



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00067320

29d. Date signed (Month, Day, Year)

2009

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if it is reflicted from the configuration of the property. Baltimore, Maryland 21215-0036

Physicia

**Examin** 

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, 🔿

	For State Registrar						Ce	rtificate d	of Dea	ath		Reg. N	No.2 ()	09	2769
	1. Decedent's Nam	e (First, Middle	e, Last)								2. Date of D Month		Day	Year	3. Time of Dea
	Doris			W	ilsc	n					AUG. 8				
To Be Completed by Physician/Medical Examiner	4a. Facility Name (		-					4b. City, Tow	n, or Loca	ation of Death					
	Prince Ge 5. Social Security N		Ho 6. Sex				a a t h inth da u	Cheve 1		Inder 24 Hrs.	9 Date of B		rinc		
	579-16-59			к ]м 2 <b>∑</b> ДГ	7. Age	79	ast birthday) Yrs.	Months Da		ours I Min. I	(Month, L	ay, rea	1929	Coi	untry)
	Usual Residence of					13					AUG. 8, 2009  Death  AUG. 8, 2009  11  4c. Country of Death Prince George  Hrs. 8. Date of Birth (Month, Day, Year) NOV. 19. 1929  UNK.  10d. Ins				
	10a. State	10b. County				10c. City	, Town or Lo	cation				Reg. No.   3. Tin the pay year   3. Tin the pay year   3. Tin the pay year   4c. County of Death   Prince George   9. Birthplace (Scountry)   19. 1929   UNK.   10d. Inside   10d. Insid	10d. Inside City L		
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a	2425 25t1	St. S	E					20020	)			Uni	ted	Stat	es
2	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	_	ried	12. Was Dec Armed F 1 ∐Yes If Yes, G Year or I	orces? 2X11 ive			Was Decedent If Yes, specify 0 1 □Yes 2 <b>X</b>	uban, Me	ic Origin? (Specexican, Puerto F Decify:	cify Yes or N Rican, etc.)	0-	Bla	ck, White	e, etc.
) ied	(620)	15. Deceden	t's Edu	cation	1			dent's Usual Oc		most of working	a	16b.	Kind of E	Business/I	Industry
T T	Elementary/Seco	eify only highe ndary (0-12)	J. grade	College (		+)	`life.	DO NOT use re		, HOUL OF WORKIN	9				
	UNK.						UNK.				/F		Day Year 2009		
De	17. Father's Name	(First, Middle,	Last)								(First, Middl	e, Maid	en Surna	me)	
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	19a. Informant's N							•					-		
	Frances 1	<u>-</u>	ıard	ian		201- 5									
	20a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation 5 ☐ Other (S	pecify)		State	Riv Par	erdale k	Cremate	ry	AUG. 2009				,	
	21. Signature of Fu	meral Service	Licens	ee {		M00	956   <sup>2</sup> 1	Name and Ad Thibadea 133 Gist	u Mo .u Ave	rtuary L., LL,	Servic Silve	e. Šp	P.A.	, MD	ath eorge's irthplace (State or Fountry) K.  10d. Inside City In the state of the s
	Sequentially list co if any, leading to in cause. Enter Unicate Cause (Disease or that initiated events resulting in death)	injury	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	VENT	(or as	a consequ		ANT RES	PIRAT	ΓORY ARE	REST				
ysician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months?			birth gnant a	of pregna 2 ☐ Fetal t time of d	death 3	⊒ Ectopic pregr ⊒ Other <i>(specif</i>				United State  14. Race Black, Whit African Black, Whit African Specify:  16b. Kind of Business.  UNK.  Ite, Maiden Surname)  Ite, Maiden Surname)  Ite, City or Town, State, gton, DC 200  20c. Location - City or Glen Burnie  Ce. P. A. r Spring, MD  Arrest,  23d. Date of de Month  d tobacco use contribute to death? so yone)  as an topsy orformed? so 20No 1   Yes yone)  Periode how injury occurred  Ite cause(s) and manner and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) and the cause(s) a			
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шріете											aut	ODSV	- 1	prior to	completion of caus
	25. Was case refer	red to medica	· I						26	Place of Death			No	1 ∐Yes	2 LANO
۵	examiner?		· -	Hospital: ₁Ⅸ	] Innatia	ent 2 🗆	FR/Outnatio	nt 3 DOA	Othor:		,		6 00	ther /Soc	cify)
ation: I	27. Manner of Deal 1 X Natural 2	h 5 🗆 Pendir investi	gation	28a. Date		ry	28b. Time of Injury	f 28c.	njury at Vork? 1 □Yes	2					ony/
	3 ☐ Suicide 4 ☐ Homicide	6		28e. Plac build	e of Injuding, etc	ury - At ho c. (Specify	me, farm, st	reet, factory, off	ce	2				ber or Ru	ural Route Numbe
2	29a. Certifier (Check only one)	2☐ Medical	Exami		basis o	f examina		nvestigation, in	ny opinio	n, death occurre		e, date	and place	e, and due	e to the cause(s)
ledical Certification: To Be Completed by Physician/Medical Examiner		title of contitio	r					29c. Lie	ense nur	nber		29d.	Date sign	ed (Mont	h, Day, Year)
	29b. Signature and	ess of person	1	2k	5				12,	2577	7	0	18-	//-	3. Time of D 11:30  art 11:30  art 11:30  art 11:30  art 11:30  art 11:30  art 11:30  art 10d. Inside City  1X Yes 2  Country?  Ites  merican Indian, hite, etc.  In America  ass/Industry  ass/Industry  art 20910  Approximate Interval Betwonset and December 100  Approximate Interval Betwonset and December 100  Approximate Interval Betwonset and December 100  Approximate Interval Betwonset and December 100  Approximate Interval Betwonset and December 100  Between 100  Be

DHMH 17 Rev 1/2001

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 6:00 p M Lorraine Harris Webb August 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Casey House Rockville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 🔀 F Director 220-88-1584 October 27,1963 District of Columbia 45 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at Director 1 ☐ Yes 2X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 1716 Colesberg Street 20905 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No If Yes. Give Specify \$ 3 Widowed 4 Divorced Year or Dates White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygien Important: If item 27 is marked other th: any injury or other traumatic event, the once. 12 Secretary Legal Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Kathryn Chinn ဥ William Compton Poling, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7360 Stone Court, St. Leonard, Maryland 20685 Mary Kathryn Bergsman - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 08/14/2009 Clarksville, Maryland 21. Signature of Funeral Servix Litensee M00143 . Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Hepatic Cirrhosis /Medical Due to (or as a consequence of) Examiner Hepatic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) certificate be executed Exam Alcohol Abuse burial-tra Due to (or as a consequence of) inding physician ause as the burial Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 🗷 No o detached 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate rmed? 2. █No Vital 2 🗆 No 1 □ Yes 1 TYes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 Yes 2 No Medical Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Division of 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? Hospital or Attending (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

3

Slit- Per Charlottel Stel

Jocelyne Toukep Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

August 12, 2009

Koucetehou,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physici /Medi Examir

Funeral Director

For State Registrar					•	ificate of	lealth and l Death		Re	g. No.			1000
Decedent's Nar	me (First, Mida	lle, Last)						2. Date	e of Death	1 _ 6	1005		of Death
Arbutus	Mae Wh	norton						Aug	üst	1 <sup>Day</sup>	2009	7:3	30 A M
-		on, give street and r	number)			4b. City, Town, or	Location of Deat	h			County of Dea		
Golden						Hagers If Under 1 Year	town If Under 24 Hrs.	1 0 D-1	-4 D:-N-		Washin	<u> </u>	
5. Social Security		6. Sex 1 ☐ M 2X F		n yrs. last bir. 32		Months Days	Hours Min.	(Mo	of Birth nth, Day,	Year)	9. Bir	thplace (Sta: ountry)	te or r-oreign 1D
218-24- Usual Residence				)4				1057	06/19	021		T.	<u>ш</u>
10a. State	10b. County	у	10	c. City, Town	or Loca	ation							City Limits
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10e. Street and N 1014 Br		Orive, Co	ndo 20	)2		10f. Zip Code 2174	ŧO		10	g. Citiz US	en of What Co	ountry?	
11. Marital Status		12, Was De	ecedent Eve		13. Wa	as Decedent of H	lispanic Origin? (S	Specify Ye	s or No-	1	4. Race - Ame		,
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17. Father's Name		. Last)			nous	ekeeper	18. Mother's Na	me (First.	Middle. N			.10	
John Le							Flore	, ,			,		
		ship (Type. Print)		19b	. Mailing	Address (Street	and Number or R					Zip Code)	
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20a. Method of Di				20b. Place of	Disposi	ition (Name of atory or other place	ce)	Date	2	20c. Loc	cation - City or	r Town, State	)
	2 □Cremation 5 □Other (	3 □Removal fro Specify)	om State	Manor			08/1	10/20	00	Boo	nsboro	MD	
21. Signature of I	Funoral Sancio					IC LCT A	100/3	レンノムロ	ロター	DOC	TIPDOLO	, μυ	
	- WHOIGH GOIVIO	e Licensee	6			Name and Addre					mich F	•	l Home
2	3	e Licensee			22.	Name and Addre		Geral	d N.	Mir	nich F	unera	
23a. Part1. Enter shock, or he	the disease.	e Licensee or complications tha st only one cause o	at caused the	e death. Do	30	Name and Addre	ess of Facility (	Geral reet,	d N. Hage	Mir erst	nich F	unera D 2174 Approxi	+0 mate Between
Immediate Cause disease or condit	r the disease, ceart failure. Lise (Final	or complications that	at caused the n each line.	e death. Do	30	Name and Addre	ess of Facility (COMAC Str	Geral reet,	d N. Hage	Mir erst	nich F	unera D 2174 Approxi	40 mate
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State Registrar

WH-3

31. Date filed (Month, Day, Year) AUG 18 2009 DHMH 17 Rev 1/2001

32. Registrar's Signature porce Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 30 per DVR C894 8/31/09 dk
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Glate of	iviai yiai		ertificat	e of L	Death	7		Reg. N	00000	276	97
			1. Decedent's Name (First, M	ddle, Las	st)			-				2. Date of De Month		ay Year	3. Time of D	beath "
	Physicia /Medic	al	MARGARE		MARY		WILE	CINSON				AUGUST		ay, 2009 Year	3:56P	IVI
4.	Examin	_	4a. Facility Name (If not institu								of Death		4	c. County of Deat FREDERT		
and the				MEMO. 1 6. s	RIAL HOS	PTTAL  '. Age (In yrs	last hirthd		ERIC r 1 Year		er 24 Hrs.	8 Date of Bi	rth		hplace (State or	Foreign
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	ms 2	Funeral	11. Marital Status		12. Was Deced	lent Ever in U	J.S. 1	3. Was Dece	dent of H	lispanic C	Origin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - Ame Black, White		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a second the standard of the second that the matural, or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divor		1 ∐Yes If Yes, Give Year or Da	2 [ <b>X</b> No e		1 □Yes		Specif				Specify: Wh		
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Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Juneral Ser	vice Licer	osee			22. Name a Restha	nd Addre	ss of Fac Fune	ral S	Service	s, S	Skkot Cod erick, M	dy P.A.	
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	5		30. Name and address of pe	erson who	completed caus	se of death (I	tem 23a) (T	ype, Print)								
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09-06187 Letty Willia

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ity vviiliams		State of Maryland / Department of Proceedings of State of Maryland / Department of State of			d Menta	al Hygiene	Reg.	No. 200	9 2769
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Letty Williams				2. Date of Month Augus	Death	lav Vear	3. Time of Death 0754 hrs
		4a. Facility Name (if not institution, give street and number) Sharrett Road & Francis Scott Key Highway	41	4b. City, Town, or Location of Death Keymar 4c. County of Death Carroll					h
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under 1 Yea Months Day		1.60	of Birth( 26/1	MM/DD/YYYY) 9. Bit	thplace (State or gn puntry) Kansas
ı,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	Yrs.			047	20/1	.943_	10d. Inside City Limits
ınd show ar	'n	100.000, 100.00	gewat						1 Yes 2 X No
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number 3832 Glebe Meadow Way		10f. Zip Code 21037			1 -	Citizen of What Cou	•
ath with 1 items 23a	Funeral	11. Mantal Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces?				n? (Specify Yes of Puerto Rican, etc.		14. Race - Amer White, etc.	rican Indian, Black,
s after de ral", or i	by Fu	3 Widowed 4 XDivorced of Dates:	-	Yes 2 X No				Specify.	ite
36 nin 72 hour: e. than "natu dical Exan	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	s Usual Occupated to the state of working life to the state on Technology.	. DO NOT us	se retired)	- 1	6b. Kind of Business, Defense Cont	
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Be Com	17. Father's Name (First, Middle, Last) John J. Williams			18.Mother's Jean M	Name (First, Mid lurphy	die, Mai	iden Surname)	
MD 21 12 should ! th and Mer 1.27 is mar umatic eve	101		. Mailing 32 G					er, City or Town, State er, Maryl	
Baltimore, MD bernit. Pages I and 2 sho Department of Health and Important: If item 27 is njury or other traumati		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:	f Disposit ory or othe Crem	ion (Name of ce er place) atory	- 1 ·	Date 08/14/09		20c. Location - City of Edgewater	Town, State , Maryland
Balti permit. Departm Importa injury o		21. Sign ture of Funeral Service Licensee	22. Na	ame and Address	ons Is	eorge P	. Ka	las Funer Edgewater	al Home , MD 21037
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.							Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):							Dedair
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
uted 1d ransit	l Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.							
60, ate be exec ohysician ar e burial - t	<b>N</b> edical	UNPENDED AMENDED						E	
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  Live birth  2 Pregnant at time of death		al death 3	Ectopic p	pregnancy		23d. Date of delive Month	Day Year
Box he death y the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown		er (Specify)	i e la Data	1 220	Old taba		the cause of death?
s, P.O. E irres that the c signed by the	ρ	Part II. Other significant conditions contributing to death but not resulting	in the un	denying cause (	given in Pan		_	2 ✓ No 3 Pro	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed					_	Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
tal Rec	Be Co	25. Was case referred to medical examiner? Hospital: Inpution: 2 FR/Out				Check only one)	res 2		
1 of Vital ling Physician: After this certifuneral director	7: To	27. Manner of Death 28a. Date of Injury 28b. T	utpatient Fime of Inj		Other <sub>4</sub>		ribe hov	w injury occurred	
Division Isl or Attendi Is after death. Is Director: /	catio	1 Natural 5 Pending Investigation 2 Accident Aug 8, 2009 0739			Yes 2 V	10		ured in airplane	ural Route Number, City
Divis spital or At tours after d neral Direct	Certification:	4 Homicide determined (Specify) Field	m, street	, ractory, office E					Highwa, Keymar, MD
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.							
	Me	29b. Signature and title of certifier		29c. Licens				29d. Date signed (Me	onth, Day, Year)
15		30. Name and address of person who completed cause of death (Item 23a)	1.0-			D 04004			
	ate	31. Date filed (Month Day Year) 32 Registrar's Signature		Street, Balt	imore, M	J 21201			
Regist	rar	AUG IJ LUUY Chara A.	Sax						

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

09-06474	
Gerald Adams	

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2009 2769	2009 27	69	1
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oraid / idamo		- For State	Cert	tificate of Death		Reg.	No.	
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,La	st			2. Date of Death	Day Year	3. Time of Death
Medical Examir	ner	Gerald	Haams_			August 18, 2	2009 4c. County of Death	2250 hrs
)		<ol> <li>Facility Name (if not institution, g</li> <li>2216 Lyndhurst Street</li> </ol>	ve street and number)	4b. City, To Baltim	own, or Location of Death	1	N/A	1
Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. la			8. Date of Birth	MM/DD/YYYY) 9. Bir	thplace (State or
Director		011 00 0 110 -	M 2 F	57 Yrs. Months			Foreig	ountry) NC
	-	Usual Residence of Decedent		<u> </u>	<u> </u>	100 at		
any	Ī	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	5	MD NA	Ba	Himore				1 Yes 2 No
Mary	Director	10e. Street and Number	1 0	10f. Zip (		109	. Citizen of What Cou	intry?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		2216 Lynch			al ( nt of Hispanic Origin? ( S	pocify Ves or No.	14 Pace - Amer	ican Indian, Black,
ath wi	Funeral	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in U.S d Armed Forces?	If Yes, specify	Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	an indian, black,
fter de		3 Widowed 4 Divorce	1 Yes 2 No	1 Yes 2	No specify:		Specify: B	lack
hours afte "natural", Examiner	<del>g</del>	15. Decedent's Education (Specify	only highest grade completed)	16a. Decedent's Usual C	Occupation (Give kind of king life. DO NOT use ret		6b. Kind of Business/	Industry
36 thin 72 ho te. than "n	lete	Elementary/Secondary (0-12)	College (1-4 or 5+)	0 1		iii ed)	110000	LCUX
5-0036 led within 72 Hygiene. other than the Medical	Completed	12 years 17. Father's Name (First, Middle, Las	5+ years	Code	·	e (First, Middle, Ma	UNIVERSITE SUPPLEMENT	TY OF NYD
	Be C	1	Kens		Blanc		Jams	•
2 a & a s		19a. Informant's Name/Relationship			(Street and Number or	Rural Route Number	er, City or Town, State	e, Zip Code)
MD d 2 shotth and a 27 is rumatic		Raymond Ac			ells Circle		adelha,	PA 19129
ore, ME ss 1 and 2 s of Health at If item 27 her trauma		20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Disposition (Nam rematory or other place)	e of cemetery,	Date	20c. Location - City of	r Town, State
Pages nent of ant: If		4 Donation 5 Other Specia		rrison for		31-09	Owingsl	yills, MD
Baltimore, permit. Pages 1 at Department of He Important: If ite	1	21 Signature of Funeral Service Lice	enseg	22. Name and	Address of Facility VQ	many c	reenestu	neral Serve
	-	23a. Part I. Enter the disease, or con	polications that caused the death.	Do not enter the mode of	f dving, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval
Physician /Medical		failure. List of ly one cause on			, ,	, ,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of					
		Sequentially list conditions,	)					
	Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of	):				
p is	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	):				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit			d.					<del> </del>
60, ate be er ohysician	Medical	UNPENDED  IF FEMALE:	AMENDED				23d. Date of deliver	]
876 tificat ng ph	-	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	2 Fetal death	3 Ectopic pregn	ancy		Day Year
Box 687 death certifications at the attending ped for use as t	sician	1 Yes 2 No 9 Unknow	4 Pregnant at time of dea		ify)		Î	
D. Bc t the dea	Phy	Part II. Other significant conditions	9 Olikilowii	esulting in the underlying	cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ires that to signed by the detact		Tark in Canal Significant Control	osimipaming to dodn's at more	assuming in the cheering	<b>3</b>	1 Yes	2 No 3 Pro	obably 4 Unknown
ds, equire	Completed by		<del>-</del>			24a. Was ar		utopsy findings available completion of cause of
e faw e	립					autopsy perform	ned? death?	r 7
tal Rec ician: The certificate rector. page		25. Was case referred to medical			26.Place of Death (Check	1 Yes 2	NO I	es 2 110
of Vital Records, in Physician: The law require this certificate has been simeral director, page 2 should be	e Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2		Othor: 5 3		esidence 6 🗸 Othe	er: Scene
n of ding Ph.		27. Manner of Death	28a. Date of Injury FOUND:		28c. Injury at Work?	28d. Describe ho Subject cut s	ow injury occurred	
ion Itendi Icath. Itor: /	atio	Natural 5 Pending Accident Investiga	ation Aug 18, 2009	FOUND: 2235 hrs	1 Yes 2 V No			
Division fal or Attendii rs after death. al Director: A	Certification:	3 Suicide 6 Could no determin			office building, etc.	or Town, Sta	ate)	ural Route Number, City
Divi		4 Homicide	1000 TOWINGUSE		time data and place on		street, Baltimore,	20
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	Certifying Files	cian: To the best of my knowledger: On the basis of examination ar	ge, death occurred at the nd/or investigation, in my	opinion, death occurred	at the time, date an	nd place, and due to t	the cause(s)
To To com	Mec	29b. Signature and title of certifier	and manner stated.		License number 4		29d. Date signed (M	
		6/11/11	111	(.	O.C.M.E.		August 19, 2009	9
<u> </u>	ł	30. Name and address of person wh	o completed cause of death (Item				,,	
V			sistant Medical Examiner	the state of the s	t, Baltimore, MD 2	1201		
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	alle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 👇 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 30, 2009 Physician Margaret Mary Allen 5:45 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Old Court Baitimore Randallstown 8. Date of Birth (Month, Day, Feb. 4, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Year) 1917 Months Days Hours Min Maryland 214-12-9999 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XNo Director Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code United States 3505 Millvale Road 21244 Funeral of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XX lever Married 2 Married Specify: White 1 □Yes XXNo Specify: à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Casualty Elementary/Secondary (0-12) College (1-4or 5+) 12th Insurance Company Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. Allen Mary E. Brady ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa M. Moreland (Niece) 4412 Vale Drive, Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sep. Date 3 1XXXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Holy Family Cemetery: Harrisonville, Maryland 21. Signature of Funer 1.S. price Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. Emain 11605 Reisterstown Road, Owings Mills, MD 21117 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immadate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760 P.O. Records, Division of Vital

law requires that the death certificate be executed physician and s the burial-trans as attending p nse s signed by t cate has t certificate Attending Physician: director this After th funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu ö

**Funeral** 

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Examinan barrofilied at

**Physician** 

/Medical

Examiner

3altimore, Maryland 21215-0036

State Registrar

29a. Certifie (Check only one)

29b. Signature and title of certifier

MD

29c. License number

Owings

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of geath (Item 23a) (Type, Brint)
20, Crossroads Drive Scule 101

32. Registrar's Signature

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

filled in by the funeral director. Hospital or Attending 24 hours after death. Funeral Director: / completely within 2 To the

> State Registrar

DHMH 17 Rev 1/2001

Medical

4 ☐ Homicide

29b. Signature and title of certifier

AUG

29a. Certifier

S-OSBORNE

and manner stated.

1411

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. M/RANDA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ATE IOL

29d. Date signed (Month, Day, Year)

			For State	State of	f Marylar		artment of h <i>rtificate of</i>		Mental Hy	000	0 0 7 7 0 0
-			Registrar  1. Decedent's Name (First, Middle, Las	st)		Ce.	runcale or	Deain	2. Date of De	Reg. No.	3. Time of Death
	Physici		JAMES	ALEXANI	ŒR	ARMS	TRONG, J	TR.	Month AUGUST		12:15P <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, giv	street and nur	nber)	111415		or Location of Deat		4c. County of	
es de			CHERRY LANE NURSI	NG CENT	ER		LAUREL				GEORGE'S
	Funeral		5. Social Security Number 6. S	ex SatM 2□ F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	(Month, Da	rth a <i>y, Year)</i> 10 1931	9. Birthplace (State or Foreign Country)  Md.
	Director		577-34-7556 Usual Residence of Decedent		78				March .	10 1931	Ma.
ryland	how		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
e Ma	Ba-f s	cto	Md. Prince (	eorge's	5		Laure1				1 ∑Yes 2 □ No
vith th	or 2	Dire	10e. Street and Number				10f. Zip Code	00700		10g. Citizen of Wh	-
eath v	ns 23amust	Funeral Director	9001 Cherry Lar		dent Ever in U	S. 13.	Was Decedent of h	20708 Hispanic Origin? (S	Specify Yes or No		States - American Indian,
o fter d	r iten iner		1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ∐Yes	rces? 2√∏No		Was Decedent of H		to Rican, etc.)		White, etc.
<b>5-0036</b> 72 hours aft	ral",o	d by	₩ Widowed 4 Divorced	If Yes, Giv Year or Da			1 □Yes 2 🙀 No	Specify:		Specify:	B1ack
2-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	"natu dical	letec	15. Decedent's Ec (Specify only highest gra	ucation de completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wor	rking	16b. Kind of Busi	ness/Industry
G Z IZ I 3-UU 36 filed within 72 hours after death with the Maryland	than	Completed	Elementary/Secondary (0-12) 12th	College (1	-4or 5+)	me.	Printer	u)		Prin	ting
filed	other ent, I	Be	17. Father's Name (First, Middle, Last)			.L		18. Mother's Nar	me (First, Middle	, Maiden Surname)	)
yland suld be file	Venta rrked tic ev	70 B	James A. Armstı	ong, Si	·			J <b>u1i</b> a	Stone		
<b>Viar</b> ) d 2 sho	is me	ľ	19a. Informant's Name/Relationship (	Type. Print)		19b. Maili	ng Address (Street	and Number or R	ural Route Numb	per, City or Town, S	tate, Zip Code)
6, <b>8</b>	Health		Randy Edwards / S	Son	206.	202			ash., Do		ity or Town, State
ages 1	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🔀 Cremation 3 ☐		State		osition (Name of matory or other pla				ville, Md.
Saltimor permit. Pages	artme ortani injury		4 □ Donation 5 □ Other (Specifical Licers)  21. Signature of Funeral Service Licers		CII		ke Cremat  2. Name and Addre			Mortuary,	
pem pem	any any onc		MANN A	Russa	Jul	10	425 Mary1	C	_	Wash., DC	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olications that c	aused the deat	h. De not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between
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ertifica	ing pl e as t		IF FEMALE:	20-15							
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j ş	y the	nysic	1 □Yes 2 □No 9 □ Unknown	9 Unkn		ueaui 5	Other (specify) _				
S that	gned b e deta	by Pł	Part II. Other significant conditions of	ontributing to de	eath but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
ecords, law requires t	en siç ould b		DEMENTIA						1 🗆	Yes 2 □ No 3	B ☐ Probably 4 🔀 Unknown
law r	as be	Completed	HYPERTENSIO	NN					24a. Was	psy pr	ere autopsy findings available for to completion of cause of
The T	cate l	Con	DEPRESSION								eath? □Yes 2 <mark>52</mark> 1No
VILAI Sician: 1	certif	Be	25. Was case referred to medical examiner?	Hospital:		1==:-::::::::::::::::::::::::::::::::::	Ott		ath (Check only		
2 E	er this eral di	1: <b>T</b> o	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	Inpatient 2 C	28b. Time o	nt 3 🗆 DOA	, 4 Nursing F		how injury occurred	
SION	ath. r: Afte ie fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day, Year)	Injury	M 1	rk? ]Yes 2□No			
r Atte	ter de irecto n by tf	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location ( City or To	(Street and Number wn, State)	r or Rural Route Number,
oital o	urs af eral D illed in		200 Contidor 157 Constituing Di	valeian. To the	has at muchan		the consumer of the state of	i data and alam		(a) and mar	and a stated
Host	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		niner: On the b						e cause(s) and mar , date and place, ar	nd due to the cause(s)
To th	within To th comp	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			· Mu	n			D4	15217		Augu	st 27, 2009
			30. Name and address of erson who					D.c	Hoish to	мд 20	740
س	Sta	to	Asebowate Ajayi 31. Date filed (Month, Day Year)		6201 egistrar's Signa		be1t Rd.	Berwyn	Heights	, Ma. 20	740
	Registr		31. Date filed (Month, Day Year) AUG 31 ?		new		arkel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:55 рм Oyelakin Michael Aduyemi 24 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. XXM 2□F May 19, Nigeria 1992 Lagos, Director 214-75-7588 Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 X Yes 2 No Director Maryland Prince George's New Carrollton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 U.S.A. 7743 Riverdale Road #202 · death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status should be filed within 72 hours after and Mental Hygiene.

marked other than "natural", or ite 1XXNever Married 2 ☐ Married Black Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Janet Fabuyide Lawrence O. Aduyemi ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9211 Gary Lane Upper Marlboro, Maryland 20774 19a. Informant's Name/Relationship (Type. Print)
Adebayo O. Aduyemi (Brother) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ction Cem. | 8/31/2009 | Clinton, MD
22. Name and Address of Facility Marshall's Funeral Home, 1kc. 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 21. Signature of Funeral Service Licenses 4217 9th Street, N.W. Washington, D.C. 20011 OM 977 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 years Nasopharyne disease or condition resulting in death) /Medical Due to (or se a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consecuence of: sician and burial-transit law requires that the death certificate be executed Box 68760 Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No cate has been signed by the page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2XNo 24a Was an certificate has autopsy 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Linpatient 2 ER/Outpatient 3 DOA After this Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

P.O. Division of Vital Records, within 24 hours after death

To the Funeral Director: completely filled in by the f Hospital

State Registrar

Elizabety 31. Date filed (Month, Day,

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

005

29c. License number MD

29d. Date signed (Month. Day. Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ESWICK tome 2/tomare 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Year) Months 1 □ M 2 🗗 F North Carotina 313-16-4149 Yrs. Director Usual Residence of Decedent 10d. Inside City\_Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Nes 2 No IA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cubap, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1ac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than Med Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hark permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any Injury or other trau Ave, Apt 201 Heights Balto MD 21268 Neice )avis 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ineral Service Licens MD 21207 4400 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) dementia end stage **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for a Month Day Year in the past 12 pronths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) Division or Vital Records, P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 1□ Yes 2 NO ours after death.

neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be examiner's Hospital: 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 1 Matural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 35102 August 28, 2009 Street Boltmurimaryland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAYLES 5901 North

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Don

m. 9.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CATHERINE BUTT 27,2009 MARIE AUGUST **Physician** 2:00P M /Medical 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8435 COCO ROAD ROSEDALE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 212-52-9780 6. Sex **Funeral** Days Months 1 □ M 2 X F Director 6-7-1908 MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ---- and Injury or other traumatic events. 10d. Inside City Limits 10a. State 10c. City. Town or Location ROSEDALE 1 □Yes 2X No Director MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 U.S.A. 8435 COCO ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 📉 No ģ Specify: WHITE 3 N Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (BURKHART) BARBARA ANN JOHN SCHLACH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5530: 10451 GREENBRIER RD UNIT 221 MINNEIONKA, MY 19a. Informant's Name/Relationship (Type. Print)
VIOLA EDWARDS/SISTER-IN-LAW Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 9-3-09 Burial 2 Cremation 3 Removal from State ELKRIDGE, MD MEADOWRIDGE MEMORIAL PARK 4 Donation 5 Dother (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Foneral Service Licensee 21237 1211 CHESACO AVE ROSEDALE, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) P.O. 1 □Yes 2 No filled in by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2/X No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SCHResidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Exeminer: On the basis of examination and/or investigation in my opinion death accurred at the time. 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 296. Signature and title of certifier 29cs License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) MD 2123 110 phia

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:05 P Milton Leo Barth, Sr. Aug 24, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline 4639 Bethlehem Rd. Preston Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Min. Days 10 M 2□ F Director Yrs <u>218-26-2001</u> 79 MD Jan 31, 1930 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hyglene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other thaumatic event, It. Medical Expirime must be notified at ury or other traumatic event, It. Medical Expirime must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 No **Funeral Director** MD Caroline Preston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4639 Bethlehem Rd. 21655 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11/12 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 11/12/195 1 ☐ Yes 2 KLNo Specify. Completed by Specify: White 3 Widowed 4 ☐ Divorced 11/12/195 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Bottler** Brewing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Howard Barth Rachel Warfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Peugh Daughter 4639 Bethlehem Rd. Preston, MD 21655 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1☑Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Aug 28, 2009 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. At the diversity, or complications the caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** obstruct /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending М investigation 1 ☐ Yes 2 □ No 2 ☐ Accident

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signature

M

and manner stated.

30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print)

6 Could not be

determined

3 ☐ Suicide

29a. Certifier

4 🗍 Homicide

29b. Signature and title of certifier

ORIGINAL

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0149 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Hospice of the Chesapeake Harwood 8. Date of Birth (Month, Day, Youly 22, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Year) 1932 Days Hours 1 M 2 F Maryland 215-26-3017 Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arthent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, ha. Medical Exercition and the profiled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Exeminates authoritied at Director 1 □Yes 2√□No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Alder Road 21403 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 K Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) 12 0 programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clark Heimark Barr Sr Doris Susan Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains 813 Parkwood Avenue Annapolis, MD Carol Novella/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dotner (Specify) permit. 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RAG. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi that initiated event resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical (F FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA HOSPEE 27. Manner of Death 1 ☑ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranter stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

Name and address of person who completed

31. Date filed (Month, Day,

441

ase of death (Item 23a) (Type, Print)

MM

Registrar's Signature

T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 August 26, 9:55P LAMWAKA MARTIN BILLI JOYCE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death None University of Maryland Medical Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day Year) | Dec 25, 1968 Birthplace (State or Foreign Gountry) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 1□M 2XX 40 Juba 214-81-0830 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√XYes 2 □ No Baltimore Maryland None 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21239 5802 The Alameda 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XX Married 1 □Yes 2 🗶 🖔 o 3 Widowed 4 Divorced Black Ye ar or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Laundry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cecelia Martin Martin Billi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5802 The Alameda Baltimore, Maryland 21239 Peter Abore Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Sept 5,2009 St Mary's Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Firtchell-Wielefeld Funeral Home Inc Ignature of Funeral Service Licensee enness 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final one month Pulmonary Embolis disease or condition resulting in death) Due to (or as a consequence of) two weeks Choriocarcinoma Dua to for sele consequence off 9 years HIV Due to (or as a consequence of):

Physician /Medical Examiner

attending physician and for use as the burial-tran

certificate has been signed by the rector, page 2 should be detached

director,

funeral

filled in by the

completely

I or Attending Physician; after death.
Director: After this certifica

To the Hospital or within 24 hours at To the Funeral D

P.O. Box 68760,

Division of Vital Records,

certificate be

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. The terms 23a or 28a-f show other traumatic event, the fired Event and the traumatic event, the fired Event and the fired filed and other traumatic event, the fired Event and the fired filed and other traumatic event, the fired field Event and the fired filed and other traumatic event, the fired filed Event and the fired filed and the fired filed f

within 72 h

2 should be finance and Mental F

permit. Pages 1
Department of H
Important: If ther
any injury or oth

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to industriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exam

23c. If ves. outcome of pregnancy 23d. Date of delivery

23b. Was decedent pregnant in the past 12 months? 9 Unknown

Physician/Medical

≥

Completed

Be

Certification: To

1 ☐ Live birth 2 ☐ Fetal death Ectopic pregnancy Other (specify) 4 Pregnant at time of death

Molar Pregnancy

Month Day Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown 24a. Was an autopsy performe 2 **XX**10

26. Place of Death (Check only one)

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 💢 💢 o

> 5 Pending investigation 6 ☐ Could not be

Hospital: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Manner of Death

1XXNatural

2 Accident

3 Suicide

4 Homicide

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 1013142983 29d. Date signed (Month, Day, Year) August 26, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, Maryland 21201 Rati Patel

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MD

			For State Registrar		State o	of Marylan		artment of ertificate of			ental Hy	giene Reg. No.	2009	27709
	Physici /Medic		1. Decedent's Nam JOSEPH WAL	, , ,	,						2. Date of De Month Jugust 3		09 Year	3. Time of Death 2:55P M
	Examin		4a. Facility Name (i Stella Mari		ive street and nu	ımber)		4b. City, Town	n of Death		4c. (	County of Deat  Baltimor		
	Funeral Director		5. Social Security N 218-14-2236		Sex XXIM 2□ F	7. Age (In yrs. <b>88</b>	last birthday Yrs.	) If Under 1 Ye Months Da		er 24 Hrs. s Min.	8. Date of Bi	rth a <b>x 923</b>		thplace (State or Foreign VIand
	aryland show ed at	'n	Usual Residence of 10a. State	10b. County			ty, Town or L	ocation				-		10d. Inside City Limits 1 □Yes XX No
	with the M a or 28a-f t be notifie	Funeral Directo	Maryland 10e. Street and Nur 1723 Kurtz			Lucie	rville	10f. Zip Cod				-	zen of What Co	701
р.т. 1036	be filed within 72 hours after death with the Maryland tital Hygiene. so other than "natural", or items 23a or 28a-f show event, it a Marical Examiner must be notified at	þ	11. Marital Status	ied XX Married		2 □ No WWI ive		. Was Decedent of If Yes, specify C	of Hispanic Juban, Mexic	can, Puerto P	cify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify:	
2:55 p.m 21215-0036	rithin 72 ho ne. <b>han "natu</b> l	Completed	(Spec	15. Decedent's I cify only highest g ondary (0-12)			(Giv	edent's Usual Oc e kind of work do DO NOT use re	ne during m ired)	ost of workin	g	16b. Kir	nd of Business/	•
	d dal	To Be Co	17. Father's Name  Joseph Walt				l ui	ghway Insp		ther's Name	•	, Maiden		re County
Ma Ma	1 and 2 shou Health and M tem 27 is mar ther traumat		19a. Informant's N Ruth Ellen	ame/Relationship	(Type. Print)	Dtr	<sup>19b. Mai</sup> <b>205 C</b> r	ing Address (Str	eet and Nur te Cour	mber or Rural t #3B Al	Route Numb	per, City or Mary	r Town, State, 2 land 2100	Zip Code) <b>)</b> 9
AUGUST 30 Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		4 Donation	position  Cremation 3  5 Other (Specification Service Light)	cify)		loseph C	position (Name of ematory or other cemetery 22. Name and Ad	dress of Fa		2009 nell-Wie	Cockey edefelo		Maryland Home Inc
•	Physician /Medical Examiner		23a. Part 1. Enter the shock, or head immediate Cause disease or condition resulting in death)	the dise se, or co art failure. List o (Final on	a. ALZHE	caused the deat each line.  EIMER S (or as a conseq	DISEA						, Marylar	Approximate Interval Between Onset and Death
WE	cate be executed obysician and the burial-transit	Examiner	Sequentially list co if any, leading to in Cause (Disease or that initiated events resulting in death)	onditions, nmediate injury s Last	С	(or as a conseq	,							
d							etal death 3 Ectopic pregnancy						*	
JOSEPH BOLGIANO Vital Records, P.O. B	law requires that the death as been signed by the atter 2 should be detached for u	Completed by Phys	Part II. Other signi		contributing to d	leath but not res	ulting in the	underlying cause	given in Pa	rt I.		Yes 2	No 3 □ P.	o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of
JOSE Vital R	Physician; The law this certificate has t ral director, page 2 s	Be	25. Was case referexaminer?		Hospital:				041	ace of Death	perf 1 □ Yes (Check only	ormed? 2 X No one)	death? 1 ☐ Yes	s 2 No
Division of	ding I. After fune	Certification: To	1 ☐ Yes 2 <b>X</b> 27. Manner of Deat  1 <b>X</b> Natural  2 ☐ Accident		28a. Date (Mor	of Injury onth, Day, Year)	28b. Time Injury	of 28c. I	njury at Vork? I □ Yes 2	2	ne 5 ☐ Res 8d. Describe			ecity) HOSPICE
Divi	pital or Atturs atter deral Direct		3 Suicide 4 Homicide	determine	d 28e. Place build	ling, etc. (Special	fy) 	treet, factory, office			City or To	wn, State)	)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one X NU  29b. Signature and	1 ☐ Certifying I 2 ☐ Medical Ex- rse Prac tiple of ceptifier	aminer: On the I	basis of examina	ation and/or	investigation, in r	e time, date ny opinion, o ense numbe	death occurre	and due to the	, date and	and manner a place, and due e signed (Mont	e to the cause(s)
•	<b>∩</b> 0		30. Name and add	flux	M/N/o completed cau	se of death (Iter	n 23a) (Type	RI RI	497	92		8/2	31/200	9
	Sta	te	,	JONES, CI	RNP 230	,	EY VAI	LLEY RD.	TIM	ONIUM,	MD 21	093		
DH	Registr		AUG	312009	Bern	N. B.	pas	Le la la la la la la la la la la la la la						

09-06196 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sheila V. Berkley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Deat 1305 hrs **Medical Examiner** August 8, 2009 SHEILA BERKLEY 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's 6269 Oxon Hill Road Oxon Hill 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 2X F Country) Jan. 10 1965 579-04-2184 М 44 Usual Residence of Decedent 10a State 10d Inside City Limits 10b. County 10c. City, Town or Location X Yes 2 No "natural", or items 23a or 28a-f show Examiner must be netified at on e Md. Prince George's Oxon Hill Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6269 Oxon Hill Rd. #104 20745 United States Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 XNever Married Yes 2 X No Black Widowed 4 Divorced If Yes Give Yeer Yes 2 X No specify: Specify traumatic event, the Medical Examiner ₽ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. marked other than Private 12th Laborer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Louise Berkley Be IInknown ပ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is DeLonta Berkley / Son 4008 St., SE Wash., DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Burial 2 XCremation 3 Removal from State crematory or other place) Chesapeake Crematory 8-25-09 Beltsville, Md. Donation 5 Other Specify 21. I gn / ure of Funeral Servi / Licens 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., r complications that cause, the death. Do for enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Enter the disease. **Physician** Between Onset and failure. List only on a cau e on each line. /Medical a Salicylate Poisoning Immediate Cause (Final discase xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical 23a,2/,28a-f,permE, g896 10/13/09 TT attending physician for use as the burial -X UNPENDED IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth Fetal death Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 ✔ Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ No 3 Probably 4 ✔ Unknown Yes 2 Completed funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other: Hospital: 1 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ۵ 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural subject ingested aspirin Yes 2 X No Pendina Fd 8/8/09 Fd 1300 hrs 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) 6269 Oxon Hill Rd Oxon Hill, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be (Specify) residence

Division of Vital Records, P.O. Box 68760, To the Funeral Director: filled in by the completely

> 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year,

and manner stated

Registrar

State

Homicide 29a. Certifier 1

29b. Signature and title of certifie

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 9, 2009

VA

20002

Death

Year

No

# Baltimore, Maryland 21215-0036

	For State Registrar	Certificate of Death	Reg. No. 2 A A C	2771
Physician /Medical	1. Decedent's Name (First, Middle, Last)  Blake	4b. City, Town, or Location of Death	2. Date of Death Month Day Year  4c. County of Dea	3. Time of Death
Examiner Funeral birector	5. Social Security Number  6. Sex, 7. Age (In yrs.)  Usual Residence of Decedent	Penter Bellimire	8, Date of Birth 9. Bir	T thplace (State or Foreign Naryland
and Mental riggene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Wedlen Ever in the restliked at  To Be Completed by Funeral Director	10a, State 10b. County 10c. Ci	Ractuare  10f. Zip Code	10g. Citizen of What Co	10d. Inside City Limits 1 → es 2 □ No puntry?
al", or items 238	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U Armed Forces?  1 Yes 2 No If Yes, Give Ye ar or Dates:	2.S. 13. Was Decedent of Hispanic Origin? (Spilf Yes, specity Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)  14. Race - Ame Black, Whit	
To realit and mental rygiene. If item 27 is marked other than "natural", or i or other traumatic event, In. Madical Exer- To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)  There or Desorate	16b. Kind of Business.  Self- emill  (First, Middle, Malden Surname)	Industry
	17. Father's Name (First, Middle, Last)  James Shelley  19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura	Bran Bran al Route Number, City or Town, State,	Zip Code)
Z # E	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		Date 20c. Location - City or Dep 4201 BAHMORE	1 / 1
Importa Importa any inju	21. Signature of Funeral Service Licenses  23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility  22. Name and Address of Facility  40. 40. 40. 40. 40. 40. 40. 40. 40. 40.	anclin It. lace F.S. Balt or respiratory arrest,	Approximate Interval Between
physician and the property is the burial-transit and the property is the burial-transit and the physician and the physician is the physician and the physician is the physician and the physicia	Immediate Cause (Final	quence of):  Sheek quence of):  Derforation	Ince	a muniting
hed by the attending physicii detached for use as the bu detached for use as the bu y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of	al death 3 ☐ Ectopic pregnancy	23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions contributing to death but not res	Concer	23e. Did tobacco use contribute t	o the cause of death? Probably 4 Unknown
certificate has been signe rector, page 2 should be c Be Completed by	Sp Rence Transplant 25. Was case referred to medical	2000 26 Place of Death	24a. Was an autopsy performed? 1 Yes 2 INO 1 Yes	
r: After this se funeral dir ation: To	27. Manner of Death 1	□ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Ho  28b. Time of Injury M 28c. Injury at Work?  1 □ Yes 2 □ No	me 5 Residence 6 Other (Sp. 28d. Describe how injury occurred  28f. Location (Street and Number or R. City or Town, State)	
To the Funeral Directo completely filled in by the		owledge, death occurred at the time, date and place, attion and/or investigation, in my opinion, death occur		
сопр	29b. Signature and title of certifier	29c. License number 1619138013	29d. Date signed (Mon	th, Day, Year)
	- My V VI July	1011120		

			For State Registrer	State o	f Marylan	id / Depa	artment rtificate	of H	ealth a	and Me		giene Reg. No.	2009	27712
		74	Decedent's Name (First, Middle	, Last)						:	2. Date of De	ath	Year	3. Time of Death
Į,	Physicia /Medic		Carolyn Birch	l			,				Month 08	2 <sup>Day</sup>	2009	11:30 PM
	Examin	er	4a. Facility Name (If not institution, Heartland Nurs				4b. City, T Ade1		Location of	of Death			County of Death ince Ge	
ii.				6. Sex	7. Age (In yrs.	last birthday)	If Under 1	-	If Under	24 Hrs.	8. Date of Bir			place (State or Foreign
П	Funeral Director		577-54-8277	1 □ M 2 <b>X</b> F	6			Days	Hours	Min.	(Month, Da 08/30/	ly, Year)	Con	intry) GA
	D		Usual Residence of Decedent											10d. Inside City Limits
	show	or	10a. State 10b. County			y, Town or Lo								1 Yes 2 □ No
	the M	Director	DC NONE  10e. Street and Number		Wa	shingt	0 n 10f. Zip (	Code				10g. Citiz	zen of What Cou	untry?
	3s. or		647 Park Rd. NW	ī			200					USA		•
	death	Funeral	11. Marital Status		edent Ever in U	.S. 13.			spanic Ori	igin? (Spec	ofy Yes or No Rican, etc.)		4. Race - Amer Black, White	
9	or Its	by Fu	1 X Never Married 2 Marri	ed 1 ☐ Yes If Yes, Gi	2 XNo		1 ☐ Yes 2	221	Specify:				Specify	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vther then "natural", or Itams 23c or 28a-f show ant, I'm Medical Execution or must be rediffed at	q pe	3 ☐ Widowed 4 ☐ Divorced  15. Decedent	Year or D	Dates:	16a Dece	dent's Usual	LOccupa	ation			16b Kir	B1a	
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212	d with giene ar tha	Com	12th grade	College (	1-401 5+)	Compu	ter Op	era	tor			Dep	t. of A	rmy
Maryland	0 - 5	Be	17. Father's Name (First, Middle, I	Last)							(First, Middle	, Maiden :	Sumame)	
<u>\S</u>	2 should be in and Mental I is markad or raumatic ava	P	Robert Birch	oin (Time Delet)		405 14-15		(Ct 1 -		ie Ba		- City or	Town State 7	in Code)
<u>a</u>	d2sh thand t7 is n traun		19a. Informant's Name/Relationsh Pamela L. Birch			1	-				Washin		Town, State, Z. D.C.	20017
ō,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic a		20a. Method of Disposition	(1,200)	20b. F	_ Place of Dispo cemetery, crei			194		ate		cation - City or 1	Town, State
E	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☒ Other (Sp	3 □Removal from DecifyEntomb	State					8/31	1/2009	Bren	twood,	MD
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service L		/		2. Name and	Addres	s of Facilit	tv	L Home			
n	90 5 2 3	11. 1	19. P. 1110	Yohall			4217	9th	St.	N.W.	Washi	ngto	n, D.C.	20011
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not en	ter the mode	of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)		tastati		Cance	er						
	Examiner			Due to	(or as a conseq	juence of):								
ķ.		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
p.	cuted hd ransit	Examiner	that initiated events	С										
0,	certificate be executed ording physician and use as the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):								
09/8	icate b physic s the b	Physiclan/Medlcal		d		-						-		
× 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy						2	3d. Date of deli	verv
BOX	death le atten	iclar	in the past 12 months?	4□Preg	birth 2 ☐ Feta nant at time of d		∃Ectopic pre ∃Other <i>(spe</i>						Month	Day Year
д О	at the de by the a	hys	9 Unknown	9□ Unkr	nown									
	as tha	ру Р	Part II. Other significant conditio				nderlying ca	use give	en in Part I					the cause of death?
ord	w require been si should b		End stage rena	ıl disease	e -witho	drawn					18	Yes 2L		obably 4 Unknown
Records,	e law has b	Completed	Osteomyelitis								24a. Was	psy	prior to c	topsy findings available ompletion of cause of
<u>=</u>	Physicien: The lar this certificate has ral director, page 2		Hypertension   performed?   death?   1								2 🔀 No			
Vital	sicier certifi irecto	o Be	25. Was case referred to medical examiner?  —1 ☐ Yes2 █No	Hospital:	Inpatient 2	ER/Outpatier	nt= 3□ DO/	Othe			(Check only		G □Other (Spec	i6.1
ō	g Phy er this eral d	-	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		Bc. Injury Work			8d. Describe			ary)
lo	death. ctor: After y the funera	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	nin, Day rear)	Injury	М		res 2□	No				
Division of	or Atte	ertiflcation:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286 Place	e of Injury - At he ling, etc. <i>(Specit</i>	ome, farm, st	reet, factory,	office		2	8f. Location ( City or To			ral Route Number,
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	Hosy 24 ho Fune etely f	edical		g Physician: To the Exeminer: On the band man										
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funarel Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	. 1			29c.	License	number			29d. Date	e signed (Month	n, Day, Year)
			Susan?	my	semp	MI	) DO	026	564 <b>-</b> M	D		8/25	/2009	
	0,		30. Name and address of person v				Print)							
	10		Susan Ginsberg	<u> </u>			g St.	NW S	Suite	3045	Washi	ingto	n DC 20	010
	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Signa	hard	0							
	· ·		AUG 3 1 200	4 Char	U 1	THE PROPERTY OF								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Day **Physician** JAMES PATRICK BURNS AUGUST 2009 7:15 a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) **Examiner** MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, Une ) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1964 1 XM 2 ☐ F Niagara Falls NY Director 123-58-3255 45 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 XYes 2 No Director Norfolk Virginia the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23513 USA 4869 Norvella Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2√XNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Geoloff 12 grade Professional Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ath and Mental F. 1 and 2 should be Glenda K. Dulgarian Joseph Burns ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. <u> Ava Burns/ wife</u> 4869 Norvella Avenue Norfolk Virginia 23513 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crem. 8-29-2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th Street NW Washington, DC 20011 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC MELANOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burlal-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a d be detached for 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2: autopsy performed 2 ☐ No 2 ₩ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \( \bigcap \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, 27. Manner of Death 28h Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

V

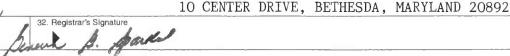
DHMH 17 Rev 1/2001

State Registrar

JENNY HONG

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D66494 MD

29d. Date signed (Month, Day, Year)

AUGUST 25,2009

# Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2009 2771										27714
Physician	1. Decedent's Nar	me (First, Middle, La:		erm.	ANI		·	2. Date of Dea Month	Day Ug 26, 200	Year	3. Time of Death  10:20 a M
/Medical Examiner		(If not institution, giv	-		7170	4b. City, Town, or	Location of Dea		4c. County	of Death	
Funeral Director	5. Social Security	Number 6. S	Woodbine Sex 7  M 2 F	. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Min	n. (Month, Da	y, Year) Country)		
	219-32 Usual Residence	of Decedent		73	Ŧ			Mar 15	1930		Od. Inside City Limits
Aaryla f shov ed at	10a. State	10b. County	I/A	Toc. City,	Town or Loc		ltimore			'	1X Yes 2 □ No
or 28a-f stoe notified	Maryland 10e. Street and N					10f. Zip Code			10g. Citizen of	What Coun	try?
ath wit	3804 Wo	odbine Avenu	е				21209			U.S.A	
72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or items 23a or 28a-f show dical Examiner must be notified at eted by Funeral Director		rried 2 Married 4 Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? No	l l	Vas Decedent of Hi iYes, specify Cuba □Yes 2 ☑ No	spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, c	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", any injury or other traumatic event, Ira Medical Estance.  To Be Completed by	(Sp	15. Decedent's Edecify only highest gra	ducation de completed) College (1-4	for 5+)	16a. Deced (Give life, L	ent's Usual Occupa kind of work done o OO NOT use retired	uring most of w )	rorking	16b. Kind of B		dustry Company
lied will Hygien ther the nt, Inc.	17 Father's Name	e (First, Middle, Last)	)			Brush	Maker	ame (First, Middle,			
Mental H arked ott attic even	17. Faulers Walli		Williams				TO. MIGHTER STA		M. McCuth		
2 shou and M is mai	19a. Informant's	Name/Relationship (	Type. Print)					Rural Route Numbe		, State, Zip	Code)
1 and Health tem 27	Deidie M. `			20b. Pla		16 Levindale sition (Name of natory or other place		more, Marylar	20c. Location	- City or To	wn, State
Pages nent of ant: If i		2 ☐ Cremation 3 ☐ 5 ☐ Other (Specif		tate ce.		atory or other place us Memorial F	, i	09/02/09	Balti	more, N	laryland
permit. Departr Importa any injt	21. Signature	Funeral Service Licer	n 58	Joh		. Name and Addres	s of Facility	neral Service, Baltimore, Mo	P. A.		
- Physician	shock, or he Immediate Cause disease or condit	tion	plications that car one cause on each	used the death.		er the mode of dying  ANCREY	g, such as card	iac or respiratory at	rest,		Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death			r as a conseque	ence of):						
ed sit	Sequentially list of if any, leading to it cause. Enter Und Cause (Disease of	conditions, immediate derlying	Due to (o	r as a conseque	ence of):						
ficate be executed physician and sthe burial-transit	that initiated even	nts	cDue to (o	r as a conseque	ence of):						
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eath certil	IF FEMALE: 23b. Was deceded in the past 1 1 □ Yes 2 9 □ Unknow	2 months?		rth 2 ☐ Fetalo ant at time of de	death 3 □	Ectopic pregnancy Other (specify)	,			ate of deliv	ery Day Year
w requires that the dispersion of the dispersion of the should be detached should by Physic	Part II. Other sign	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?									. )
ding Physician: The law requi h. After this certificate has been s funeral director, page 2 should tion: To Be Completed										prior to co death?	opsy findings available impletion of cause of
certific rector,	25. Was case refe examiner?		Hospital:			• 3 DOA Othe	ar'	eath (Check only o			
ter this derail dir	1 ☐ Yes 2	ath	28a. Date of	patient 2  E f Injury , Day, Year)	R/Outpatien 28b. Time of Injury	t 3 DOA 28c. Injury	4 LI Nursing	Home 5 Residence 1			fy)
ttendir Jeath. Itor: Af the fur	1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not b	n			M 1□'	res 2 □ No	20f Location (	Other and Museum		al Pauta Number
tal or Attending Frs after death. al Director: After led in by the funers Certification:	4  Homicide	determined	building	g, etc. (Specify)	ne, iarm, sue )	eet, factory, office		City or Tov	vn, State)	ber or Hun	al Route Number,
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur Medical Certification	29a, Certifler (Check only one)			sis of examinati				ace, and due to the courred at the time,			
To t with To t com	29b. Signature ar	nd title of contifier	MI	)		29c, License	number 062	254	MGUS	1 22	1,2009.
	30. Name and ad OUST 1	dress of person who	RUICA	- MD	241	Print) W	SELVEU.	ERE NE	BALT	Mon	CE, MOZIZI
State Registrar		3 1 2009	Denne	gistrar's signatu	parke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 4:05PM 20,2009 BARBARA J. CURTIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex Arunde Done If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 🏋 Days Min. Months Hours Director 214.42.5270 67 JULY 4, 1942 WASHINGTON, D.C. Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. Counfy 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f shou any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No Director GLEN BURNIE MD ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 404 OAKWOOD STATION RD. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give XX
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√X No Specify: þ Specify. WHITE 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **TELLER** BANK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ERNEST HATFIELD JESSE THAYER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 OAKWOOD STATION RD., GLEN BURNIE, MD 21061

Date 20c. Location - City or Town, State ARTHUR CURTIS HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNS/VILLE VETERANS CEM SEP 10,2009 CROWNSVILLE, MD re of Funeral Service 22. Name and Address of Facility FINK FUNERAL HOME, P.A. CRECORY FINK M01148 426 CRAIN HWY. SW, GLEN BURNIE, MD 21061 23a. Part I. Enter the liseas, or com, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or c vidition resulting in d vith) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) SCELENOSW cate has been signed by the attending physician and page 2 should be detached for use as the buriel trans resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 2 No 9 Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 1 □ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

21215-0036

Maryland

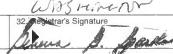
Baltimore,

State

Registrar

29b. Signature and title of celtifier

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SACO mo. 4

29c. License number

MODIGH

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 1100 P M 2009 August 26 JOSEPHINE CRAWFORD-TINDALL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 5825 GIST AVENUE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2XX 62 Yrs. SOUTH CAROLINA SEPT 16 1946 Director 218-44-6833 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1 X Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5825 GIST AVENUE 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo BLACK À Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH COSMETOLOGIST 12yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LELIA FLEMING other traumatic ပ JOSEPH BUTLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health eem 27 l 1800 Hollins St. Apt 312., Baltimore, Md 21223 Lelia Butler/Mother Pages 1. ent of Hea : If item 2. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any injury or OWINGS MILLS, MARYLAND 4 ☐ Donation 5 Other (Specifi 09-02-09 GARRISON FOREST 21. Signature Trung 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME, P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 mo Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed

**Physician** /Medical Examiner

Maryland 21215-0036

Baltimore,

signed by the a Be Certification: To this Hospital or Attending death.

requires that the death certificate be executed

or Vital Records, P.O. Box 68760,

Division

2 No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Belvedere Avenue, Baltmore MD 2/2/5

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25.	Was case referre examiner? 1 ☐ Yes 2 Z	
27.	Manner of Death	
	1 Natural	5 ☐ Pending

28a. Date of Injury (Month, Day Year) investigation 6 ☐ Could not be

Hospital:

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

29a. Certifier

2 Accident

3 ☐ Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of Certifier

Regine 31. Date filed (Month, Day, Year)

2401 gistrar's Signature

W

fter death Director

To the Hospital of within 24 hours of To the Funeral D

filled in by

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perPHYS, G895, 9/II/09, WS

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#29d, perPHYS, G895, 9/11/09, WS State of Maryland / Department of Health and Mental Certificate of Death

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evan in a rough to recitify d

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

orneltor within 24 h

A seed	State Registrar			Cei	rtificate of	Death	7		Reg. I	No. 200	9-27	7717	
	1. Decedent's Name (First, Mic	idle, Last)						2. Date of De		Jav	Voor	3. Time of I	Death
in	Elaine Carlson	n						August	2 !	$5^{\circ}, 20$	0 <sup>vg ar</sup>	8:16	Рм
al er	4a. Facility Name (If not institut	tion, give street and n	umber)		4b. City, Town,	or Location	of Death			tc. County	of Death	n	-
-I	11804 Tommy Co				Monro	ก่อ				Fre	deri	ck	
_	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		r 24 Hrs.	8. Date of Bir	th .		9. Birth	hplace (State or	Foreign
	166-40-0251	1 □ M 2 🖾 F		O Yrs.	Months Days	Hours	Min.	Nov. 2	ay, Yea 2 -	1948	Peni	untry) nsylvan:	ia
	Usual Residence of Decedent						J	2.000	_,			J	
	10a. State 10b. Cour	nty	10c. Cit	y, Town or Lo	cation							10d. Inside Cit	y Limits
Ö	M 1 1	1 2 - 1-		M								1 ☐ Yes	2 <b>X</b> No
e Se	Maryland Fred	lerick		Monro	10f. Zip Code				10g. Citizen of What Country?				
					21770						United States		
era	11804 Tommy Co		cedent Ever in U.	C 10			rigin? (Cn	pooify Voc or No				rican Indian,	
Ë	11. Marital Status	Armed F	orces?	3.	Was Decedent of If Yes, specify Cu	oan, Mexica	an, Puerto	Rican, etc.)	,		ck, White		
ž	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4   SDivorc	If Yes. G		1 ☐ Yes 2 ☑ No Specify: Spec						y: White			
Completed by Funeral Director			Dales.	16a Dooo	dent's Usual Occi	ination			16h	Kind of B	ueinace/l	nduetry	
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m d	Elementary/Secondary (0-12	Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Hospit								tali	<b>t</b> 37		
ပိ	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname									Ly			
Be									,				
မ													
	19a. Informant's Name/Relatio									-		(ip Code)	
	Loree Gearhea	rt / Daugh			Carone							- 011	
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematio	n 3 🗆 Removal from	o Stato	emetery, cřer	sition (Name of matory or other pl		Aug.		206.	Location	- City or	Town, State	
	4 □ Donation 5 □ Other		Res	sthaver	n Cremat	ory	20	009	Fre	ederi	.ck,	Marylan	ıd
	21. Signature	ce li censee		R 4	2. Name and Add esthaven	ess of Faci	lity ra1 9	Services	3. !	Skkot	Cod	v P.A.	
	10//			9.	501 Cato	ctin I	Mtn.	Hwy. Fi	red	erick	, MD	21701	
	23a. Part 1. Enter the disease	or complications that	caused the deat	h. Do not ent	ter the mode of dy	ing, such a	as cardiac	or respiratory a	arrest,			Approximate Interval Bety	veen
	shock, of heart failure. List only one cause on each line.  Immediate Cause (Final Peritoneal Mesothelioma											Onset and D	eath
	disease or condition resulting in death)  Peritoneal Mesothelioma  Due to (or as a consequence of):											6 mont	115
	Due to (or as a consequence or).												
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
m,	Cause. Enter Underlying Cause (Disease or injury	<b>S</b>											
Exa	that initiated events resulting in death) Last	CDue to	o (or as a conseq	uence of):									
/Medical Examiner		d											
g		u											
Ž	IF FEMALE:	23c. If yes, o	utcome of pregna	ancy						234 Da	ate of del	iverv	
Siar	23b. Was decedent pregnant in the past 12 months?		e birth 2 🗍 Feta		☐ Ectopic pregnar ☐ Other <i>(sp</i> ec <i>ify)</i>	ncy					onth		'e ar
ysi	1 ☐ Yes 2 MoNo 9 ☐ Unknown	9 □ Unl			a.i.o. (ope a.i.)/								
Completed by Physician	Part II. Other significant cond	litions contributing to	death but not res	ulting in the u	nderlying cause g	iven in Part	: 1.	23e. Did	tobacc	o use con	tribute to	the cause of d	eath?
d	_	ū						1□	Yes	2 😾 No	3□ Pr	obabiy 4□L	Jnknown
etec												<del></del>	
du								24a. Was	psy		prior to d	itopsy findings a completion of ca	
Ö								1 ☐ Yes	ormed 2 🔯		death? 1 □ Yes	2 □ No	
Be	25. Was case referred to medi examiner?						ce of Deat	th (Check only	one)				
٩	1∐Yes 2⊠No		Inpatient 2		nt 311 DOA		Nursing H	ome 5 🔀 Res				cify)	
Medical Certification: To	27. Manner of Death 1   ☐ Natural 5 ☐ Pender		e of Injury onth, Day, Year)	28b. Time o Injury	f 28c. Inj Wo	ury at ork?		28d. Describe	how in	njury occu	rred		
atic	2 Accident inve	stigation				□Yes 2[	□No						
tific		ld not be ermined 28e. Plac buil	ce of Injury - At he	ome, farm, str	reet, factory, office			28f. Location (			ber or Ru	ural Route Num	ber,
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g		ying Physician: To the											\
edic	one)		inner stated.	adori and/or ii	ivestigation, in my	opinion, di	eau occu	irreg at the time	, uate	and place	, and due	to the cause(s	,
Ž	29b. Signature and title of certi	fier /	1	0	29c. Licer	se number			29d.	Date signe	ed (Monti	h, Day, Year)	
	40 Seph	m. Hagy	vry m	ゾ	D 32	407			Sen	temb	er 2	, 2009	
	30. Name and address of pers												
	Joseph M. Hagg					Way,	Suit	e 300,	Roc	kvil.	1e, 1	MD 2085	0
te	31. Date filed (Month, Day, Yea	ar) / 32.	Registrar's Signa	ature									
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Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month August 29, 2009 3:02 AMM Carpenter Robert 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ESSEX If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Hours | Min. | (Month, Day, Year) 421 Virginia Avenue 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F July 28, 1938 267-50-2548 Michigan Usual Residence of Decedent 10h County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

21221

1 ☐ Yes 2X No

16a. Decedent's Usual Occupation

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

(Give kind of work done during most of working life. DO NOT use retired)

S. A.

Specify:

Flooring

18. Mother's Name (First, Middle, Maiden Surname)

16h. Kind of Business/Industry

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

Baltimore 21236

1 ☐Yes 2 ☐ No

14. Race - American Indian, Black, White, etc.

White

Onset and Death

Box 68760, o σ. of Vital Records, For State Registrar

Lynn

10a State

11. Marital Status

421 Virginia Avenue

15. Decedent's Education (Specify only highest grade completed)

1 ☐ Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

death

Director

Funeral

þ

Completed

Be

27 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Eventine in at the notified at permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or incorrection on the process any injury or other traumatic event. Lindell Carpenter Jean Eleanor Armstrona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, Maryland 21221 Deborah Helena Carpenter (Wife) 421 Virginia Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 8/31/2009 Baltimore City, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Hom 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) JEVEYE mphysemo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an has autopsy performed? 1 □ Yes 2 XNo certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No this ٩ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After: Certification: 28d. Describe how injury occurred Division Hospital or Attending 5 Pending Injury nours after death. neral Director: Aft y filled in by the fun Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0063176 August 29, 2009 and 141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair Road 31. Date filed (Month, Day, Year) wachinemere, MD. 32. Registrar's Signatu State AUG 3 1 2009 Registrar

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 105

If Yes, Give Year or Dates:

College (1-4or 5+)

1956

1960

Sales

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Day, Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 4 2 □ F Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov injury or other traumatic event, I've I've I'vanirar must be nollfied at 1 Nos 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 516 2/2 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 ☐ Married 1 □Yes 2 □ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 710 College (1-4or 5+) Curi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F ၉ 19a. Informant's Name/Relationship (Type. Print) 18b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 2 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROS **Physician** 31 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and burial-tran Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 🗐 📉 2 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 1 Certification: Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1tt Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Sta

State Registrar WBELVEDERE

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

32. Registrar's

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<sup>Day</sup> 200<sup>Year</sup> Physician Collins Joan Ricketts August 11:44 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12618 Circle Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🛛 F 577-52-9034 87 September 8, 1921 | Canada Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It., Medical Expression 1010, putfly of once. 1 ☐ Yes 2 X No Directo Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12618 Circle Drive 20850 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 👿 No Specify: White Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Designer Fashion Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Edward George Ricketts Dorothy May Townley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard F. Collins / Husband 12618 Circle Drive, Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Augus Pate 29, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Juselette Burni M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2004 Immediate Cause (Final disease or condition resulting in death) Physician Emphysema /Medical Due to (or as a consequence of): Examiner Cigarette Smoking Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Lung Mass 1 X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural I Director: A within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

Division of Vital Records,

Baltimore, Maryland 21215-0036

Box 68760

P.0.

State Registrar

filled in by

Medical

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Jerome Putnam, M.D.

10me

determined

4 Homicide

(Check only one)

29b. Signature and the of certifier

29a. Certifier

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0014111

5530 Wisconsin Avenue, #800, Chevy Chase, Maryland 20815

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

August 28, 2009

				<b>Type or Prin</b> State of Ma							egible.	
			1 - For State Registrar		,	•	rtificate of i			Reg. No.	2009	2772
	Physici		1. Decedent's Name (First, Middle, Last	ORER					2. Date of De Month	eath Day 28	2009	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	r Location of Deat			ounty of Death	232
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	Funeral Director		5. Social Security Number 6. Se	X 7. Age	(In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Yea <i>r)</i> 1923	9. Birthp Coun	place (State or Foreign otry) MD
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside City Limits
	Maryla f sho	ro	MD ANNE ARUNDE	=1		ILLERSV					Ι.	1 ☐ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number	<u>-L</u>	141	ILLERSV	10f. Zip Code			10g. Citize	en of What Coun	
	th with	al D	498 VALLEYWOOD RD				21108				USA	
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.\	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Note to Rican, etc.)	0- 14	Race - Americ Black, White, e	
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212	hin 72 e. an "na Medit	plet	(Specify only highest grad	e completed) College (1-4or 5-	+)	(Give life. I	kind of work done of DO NOT use retired	during most of word)	rking			,
7	be filed within 72 hours after death with the Maryland tial Hyglene. Id other than "natural", or items 23a or 28a-f show event, it at the first in t	Completed	Elementary/Secondary (0-12)	1		MET	EOROLOGIST				GOVT	
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<u>≅</u>	12 h 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		JOSEFA B. DORER	WIFE			VALLEYWOOD					Code)
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Ĕ	Pages ment of ant: if its ury or o		1 ☐ Burial 2 1 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State			EMATORY INC		2009	BALTIN	MORE, MD	
Baitimore, Maryland 21215-0036	permit. Page Department of Important: if any Injury or once.		21. Signature of Funeral Service Licens	MO1	148		Name and Addre INK FUNERAL 26 CRAIN HW			D 21061		
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or domb shock or heart failure. List only of Immediate Gause (Final disease or condition resulting in death)	cations that caused be cause on each line a. Due to (or as a	the death e. du	Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
,00	eath certificate be executed aftending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequa							
	ificate by g physici as the bu	edical	•	d								
.O. Box	the death certificate by the aftending phys iched for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 🗀 Fetal	death 3	Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	ery Day Year
Л.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	ntributing to death bu	it not resu	ulting in the ur	nderlying cause give	en in Part I.	"			ne cause of death?
ecord	v requ	etec								Yes 2		pably 4 Unknown
r	The lar	Completed							24a. Was auto perf 1 □ Yes		prior to co death?	psy findings available mpletion of cause of 2 No
	Physician: this certific al director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpatier	Othe	er:				
lon or	nding Physician: ath. r: After this certifica e funeral director, p	ation: To	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	v	28b. Time of Injury	28c. Injur Worl		28d. Describe		☐ Other (Specif	y)
DIVISION	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At ho . (Specify	me, farm, str	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Rura	al Route Number,
	e Hospitt 24 hours e Funera letely fille	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best oner: On the basis of and marner star	examinat	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time	e cause(s) a	and manner as solace, and due to	stated. the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier	jist /			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	HV		30. Name and address of person who co	mpleted cause of de	eath (Item	23a) (Type,	Print)	D = 11=.4	1.00 0 1	t	1	
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						ORIG	INAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #20a-c&22 Per FH G895 9/21/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Non 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** August 18, 2009 Leroy M. Duncan 9:40 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartland of Hyattsville Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) Nov 23, 1952 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Securify Number 6. Sex **Funeral** Days Washington DC Hours Min. 1 ☑ M 2 □ F Months 56 578-70-4922 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at ance. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6500 Riggs Road 20783 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Monroe Duncan Louise Rose Anderson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Duncan Libii/sister 5246 Clay Street NE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XX emation 3 Removal from State Lee's Crematory 9/15/2009 Clinton, Maryland 4 □ Donation 5 Hother (Specify) in state Name and Address of Faulty Stewart Funeral. Home, Inc.

4001 Benning RUTTE
Battimore, MD 21201 Washington D C 20010 21. Signature Funeral Service I censes Wage RD NE Washington,D C 23a. Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or consion resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed House Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 V Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after oeau..

To the Funeral Director: After 1 Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO person who completed cause of death (Item 23a) (Type, Print) 30. Name and address o DNIGIAGA KIOR HASPOVER PARKWAY 31. Date filed (Month, Day, Year)
AUG 3 1 2009

Registrar DHMH 17 Rev 1/2001

State

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Day harles 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE REMABILITATION Extended CARE BALT: MURC If Under 1 Year | If Under 24 Hrs. Ltimure 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 219.28.0978 JULY 29, 1932 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No ANNE ARUNDEL GLEN BURNIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 BROADVIEW BLVD 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 GYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes ŽX No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ROUTE SALES SNACK FOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE E. EITEL ANNA REESE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE EITEL WIFE 102 BROADVIEW BLVD. GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY, INC. 8.31.2009 BALTIMORE, MD Funeral Service 2. Name and Address of Facility FINK FUNERAL HOME, P.A. K. GRECORY TINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disc or heart failu complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Come (Final END STAGE disease or condition resulting in death) Due to (or as a consequence of): Hepatitis

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

**Director** 

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'te Modical Examiner must be notified at

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

of Health a

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. Once.

altimore, Maryland 21215-0036

Examiner Physician/Medical

attending physician and for use as the burial-transi signed by the a Completed by cate has page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be ဥ Certification:

The law requires that the death certificate be executed

P.O. Box 68760,

of Vital Records,

Division

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Dath

1 Natural

2 Accident

4 🗌 Homicide

(Check only one)

3 Suicide

29a. Certifier

Medical

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

3 Ectopic pregnancy

28b. Time of

ев в осовежнение об

Due to (or as a consequence of):

5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Hospital:

5 Pending investigation

6 ☐ Could not be

address of person who completed cause of death (Item 23a) (Type, Print)

ERTHEL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 23, 2009 **Physician** Elliston Arno1d 817 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince Georges Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 099-20-0865 Director October 21, 1929 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the medical Eventine training of 1 ☐ Yes 2 ▼No Director Maryland Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11216 Snowden Pond Road 20708 LISA 2 should be filed within 72 hours after death on and Mental Hygiene.

Is marked other than "natural", or items 23: Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. 3 Specify: Black 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) New York City Police Detective Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Elliston Winifred Pennyfeather 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any injury or other traun once. Lisa Eggleston-Niece 11216 Snowden Pond Road, Laurel, MD 20708 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery Sept. 3, 2009 Bronx, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC, 7601 Sandy Spring Rd., Laurel, MD 20707

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 1 week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septicemia 1 week Sequentially list conditions, if any, leading to immediate cause. E. it if Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of) nding physician a certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten for us 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₽ Coronary Artery Disease, Cardiomyopathy, COPD, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No Dysphagia, Decubitus Ulcers 24a. Was an autopsy certificate 1 □Yes 2 📉 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred al or Attending Fafter death.
I Lirector After do n by the funer. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check o 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature ATTENDING 29d. Date signed (Month, Day, Year) nd title of certifier AUGUT 24, 2009 D0057216 Resul PITTSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Baako, MD 7300 Van Dusen Rd, Laurel, MD 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ August 25, 2009 5:10 AM M Anna Frazier Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Jan 22, 1913 Hours 1 M 2 X 8 Director 218-30-5813 96 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 6951 Copperbend Lane 21209 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. "natural", or Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 ₩ Widowed 4 □ Divorced Specify: black Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk 16b. Kind of Business Industry (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mea Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 civil service Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Virginia WIlson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherron Green/caretaker Copperbend Lane, Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation & NOther (Specify) in state Signature of Euneral Sociate Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician Myocardial interction disease or condition days Medical resulting in death) Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery for in the past 12 months?

1 Yes 2 No Pregnant at time of death ped g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Priumonia 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? pade 2 No 1 Yes Be 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) Hospital 2 X No Other မ 1 Tyes 4 Nursing Home 5 Residence 6 X Other (Specify) Gilche's 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by determined building, etc. (Specify) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier August 25, 2009 R149194

Registrar

State

St.

Towson,

MD

N-Charles

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

Grant

Day, Year)

AUG

31

31. Date filed (Month

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 Helen P. Fehler August 7:25 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery Winter Growth Montgomery Center 8. Date of Birth (Month, Day, Year, April 25, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Hours Months Days 96 1913 Virginia 230-09-8313 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic event, the Wedical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Weden Exar, the result be a gree. 20853 15900 Maple Ridge Court United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No White Specify. Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Elementary School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I. Payne Mona Louise Graybeal Ballard ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15900 Maple Ridge Court, Rockville, Maryland 20853 Petrilli / Daughter Sara J. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parklawn Memorial Park 3, 2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 Robert A. Pumphrey Funeral Home/Roc 300 West Montgomery Avenue, Rockvill 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate
Interval Between
Onset and Death
Immediate Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction /Medical Due to (or as a consequence of): Examiner 4 Years Dementia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 History of Breast Cancer 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 □Yes 2 □No investigation rilled in by the fi 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0035045 August 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18109 Prince Philip Drive, #200, Olney, Maryland 20832 Phillip Henjum, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Backer Registrar

DHMH 17 Rev 1/2001

or Attending Physician: The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Michael ( ) 2031 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 2/18/48 Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 219–50–1948 Days 1**X** M 2 □ F 61 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Baltimore City MD N/A XXYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21230 USA 132 E. Barney Street Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No Arm
If Yes, Give Year or Dates: Viet Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No Army 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white Specify: Vietnam 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Painter 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George C. Fuss Mary Fahey 19a. Informant's Name/Relationship (Type. Print)
Karen Fuss/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 132 E. Barney Street, Baltimore MD 21230 20a. Method of Disposition
1 ☐ Burial 2★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ardent Crematory or other place) Aug. 30,2009 Hanover Maryland 4 Donation 5 Other (Specify) License Victor P. Doda, Jr. 22, Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. SIC 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Massive Immediate Cause (Final YKM10 PHS15 disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cuinto (or as a nonsequence of) Due to (or as a consequence of) IF FEMALE 23d. Date of delivery ic pregnancy Month (specify) ring cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Tes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 ☐ Yes 1 Yes

**Physician** /Medical Examiner

and

physician

signed by

has

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f sho Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be noone.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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burial-tran the as page 2 should be detached

The law requires that the death certificate be executed

or Attending Physician:

s after death.

To the Hospital of within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ò Completed the funeral director. Be ၉ Certification: completely filled in by

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	3  Ectop 5 Other
Part II. Other significant condition	ns contributing to death but not resulting in	the underly
25. Was case referred to medical		

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 1 Appatient 2 ER/Outpatient 3 DOA 1 Tes 6 Other (Specify) 27. Moviner of Death 28a. Date of Injury (Month, Day Y 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Pending investigation \*\* tural 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifie The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier -

5-000

ess of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year) 2009

park 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) AUGUST 24,2009 Year **Physician** 11:50 Рм FRANK Η. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE ENVOY OF PIKESVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-17-1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 🕅 F 068-22-5840 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natura!" ~ " any injury or other traumatic event." 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 POMONA EAST #506 21208 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2X No Specify. Specify: WHITE <u>გ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY **CLERK** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS FRANK SILVERSTEIN REBA ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LEONARD FRANK/BROTHER POMONA EAST #506, BALTIMORE, MD 21208 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 08-28-2009 EMERSON, NJ CEDAR PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final brode generature **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner -transit that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) signed by the a Ö 9 Unknow ٣. 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 3 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending 5 Pending investigation Natural 2 Accident 1 ☐Yes 2 ☐ No death. To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date/signed (Month, Day, Year) 29c. License number

State Registrar 29b. Signature and title of certifier

54. Bate filed (Month, Day, Year)

Kaymera

Mille

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Man

Street

32. Registrar's Signature

DHMH 17 Rev 1/2001

Rennistown

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	_		Registrar  1. Decedent's Name (File	rst, Middle, Last)				LIIICa	le oi D	calli	2. [	ate of Dea	th	200	7	3. Time of Death	a d
	Physici /Medio		PAULI	NE .	JANE	= 6	5018	2001	CHT	7	P	Month () S	Day	Yea		350P	М
· No.	Examir		4a. Facility Name (If not						, Town, or L		eath		4c. C	ounty of De	ath		
			Chapel Hil						anda11					1timo			
	Funeral		5. Social Security Numb	1 🗆	M 2∏ F 7. A(		last birthday) Yrs.	Month:		If Under 24 Hours N	Min. (	ate of Birth Month, Day	, Year)	_ (	Country,		
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36	after d or iten	by Funeral Director	11. Marital Status 1 □ Never Married 3 ☑ Widowed 4 □	2 Married	Armed Forces? 1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	•			edent of Hispecify Cuban,	Mexican, P  Specify:	uerto Rica	n, etc.)		Black, Wh	ite, etc.		
2-0	72 hours "natural";	ted	15.	Decedent's Educ	ation		16a. Deced	lent's Us	ual Occupati	ion			16b. Kind	of Busines	s/Indus	try UT	k
21215-0036	nd 2 should be filed within lith and Mental Hygiene. 27 Is marked other than " r traumatic event, Ire Me	Completed	Elementary/Secondary	nly highest grade y (0-12)	College (1-4or	5+)	life. L	ecto	ork done dur use retired) Y	ring most of	working	į					
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Mary			19a. Informant's Name/			er	1	-			Number or Rural Route Number, City or Town, State, Zip Code) Lane #104 Cockeysville, MD 2						
Baltimore,			20a. Method of Dispositi 1 ☐ Burial 2 ☐ Cr 4 🖾 Donation 5 ☐	emation 3 Re	11	í c	lace of Dispo emetery, cren	sition (Na natory or	ame of other place)	1	Date		20c. Loca	c. Location - City or Town, State			
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4	Physician		Immediate Caus (Final disease or condition Byces Concer Co										O	nset and Death			
	/Medical Examiner		resulting in death)		Due to (or as								-1.3-52				
	Lxammer	<u>.</u>	Sequentially list condition	ns, b.	Que to (or as		winder affir								$\vdash$		
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ć	rificate be executed ng physiclan and as the burial-transit	Exal	that initiated events resulting in death) Last	c.	Due to (or as	a consequ	uence of):								+		_
68760,	tte be iysicla ne bur	edical		d.													
			IF FEMALE:										-1		1		
Вох	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	23b. Was decedent preg	gnant j	c. If yes, outcome 1 Live birth	2 🗌 Fetal	Ideath 3□		pregnancy				23	3d. Date of o	lelivery Da	v Year	
Ö	he de / the a	ysic	1 □ Yes 2 ☒ No 9 □ Unknown		4 ☐ Pregnant a 9 ☐ Unknown	at time of d	eath 5∟	Other (	specify)							,	
σ.	that t ned by detac		Part II. Other significant	t conditions cont	ributing to death b	ut not resu	ulting in the un	derlying	cause given	in Part I.		23e. Did to	bacco use	e contribute	to the o	cause of death?	
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ita	stan: ertifica ctor, p	Bec	25. Was case referred to examiner?	medical					2	26. Place of					23 21		
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ñ	or Atter ding Physician: The ter death.  irector After this certificate h is by the funeral director, page	io i	27. Manner of Death 1.☑ Natural 5 [	Pending	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury a Work?		28d.	Describe h	ow injury	occurred			
isio	r Atter d er death. irector / n by the fi	icat	2 ☐ Accident 3 ☐ Suicide 6 [	investigation Could not be	28e. Place of In	ury - At bo	me farm etre	M Ant facto		s 2 No	201 1	postion (C	troot and	Numberar	Dural D	oute Number,	
Division of Vital Records,	ital or A urs a er ral Direc lled n by	Certification: To	4  Homicide	determined	building, el	c. (Specify	v) 					City or Tow	n, State)				
	To the Hospital or Atter di within 24 hours a er death. To the Funeral Director / completely filled in by the fi	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Physi Medical Examin	cian: To the best er: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurre estigatio	d at the time in, in my opir	e, date and p nion, death o	olace, and o occurred at	due to the o	cause(s) a late and p	and manner place, and d	as stat ue to th	ed. e cause(s)	
	To with	Σ	29b. Signature and title					2	c. License r			_	29d. Date	signed (Mo	nth, Da	y, Year)	
			Party,	CSWL					K	132	28C	0	>	2113	100	J	
			30. Name and address of	of person who con	pleted cause of	death (Item	23a) (Type, I	Print)	Persi		1			211	~		
	Sta	te	31. Date filed (Month, Da	ay, Year)	32. Registr	ar's Signa	tyre	-> , (	النسب	حرى	Ton	110	MD	< 11	20	<u>~</u>	
	Registr		AUG	3 1 2000	Cherry		1. Da	March									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** GARBER 2009/00: /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GENERAL COLUMB COUNT HOWARD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 08/13/1936 7. Age (In yrs. last birthday). Birthplace (State or Foreign Country) 5. Social Security Numbe 217–34–6103 **Funeral** 1 M 2 X F MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at **Glenwood** 1 Yes 2 No MD Howard Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 21738 USA 3732 Championship Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H item 27 Is marked oth r other traumatic even Be Clara Wilhelmina Wescott William Jacob Bissert ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3732 Championship Drive, Glenwood, MD 21738 Daniel Garber / Husband Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) f of ò 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department Important: If any Injury or once. 8/31/2009 Hanover, MD Ardent crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Dorota Marshall Maryland Cremation Services PO Box 1413, baltimore, MD 21203 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONARY **Physician** disease or condition resulting in death) ) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed sician and burial-trans MULTI Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ icate has been si, page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a, Was an autopsy certificate 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊞No **1** Inpatient 2 ER/Outpatient 3 DOA Certification: To this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide fractifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Privithin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

State Registrar

AUG 3 1 2009

29b. Signature and title of certifier

and manner stated.

29c. License number 64539

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, HOWARD COUNTY GENERAL HOSPITAL NUMURU 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Vear Physician August 2009 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1 Ge att more rive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Hours | Min. | Month, Day. Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 91 North Carolina 214-12-9568 1 M 2 M 92 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the "reflex Examiner must be notified at 1 Nes 2 No Funeral Director altimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 390 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes 2 \_\_V6 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by ack 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ZH More Hrsenia 20b. Place of Disposition (Name of cemetery, crematory or other p Location - City or Town, State Date 20c. 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howel 21. Signature of Funeral Service Licensee Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** VASCULAR DISEASE ARTERIOSCL EROTT / /Medical Due to (or as a consequence of): Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physlcian: The law requires that the death certificate be executed DIABETES and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed es 2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: investigation 1 Director: / Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

RAYNOLD DEPESTAE

31. Date filed (Month, Day, Year)

32. Regi

32. Registrar's Signature

3100 LORD BALTIMORE DR, \$110 BALTIMORE MD. 21244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last. 2. Date of Death 3. Time of Death Month Day **Physician** 12000 CATHERINE ELIZABETH HASENEI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5 en W BALTIMORE WASHINGTON MEDICAL CENTER If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 🗶 MAY 29, 1968 MD Director 212.04.3944 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machel Examinar mast to it officed at 1 ☐ Yes 2 ☐ No Director **EDGEMERE** BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21219 USA 6801 NORTH POINT RD. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: WHITE \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAW FIRM 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CATHERINE E. BLACKOWICZ ပ WILLIAM E. STINCHCOMB, JR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 NORTH POINT RD., EDGEMERE, MD 21219 HUSBAND DAVE HASENEI permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State MILLERSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) OUR LADY OF THE FIELDS CEM AUG.29, 2009 22. Name and Address of Facilit 21. Signatore of Funeral Service License FINK FUNERAL HOME, P.A. MEGRECORY FINK M01148 426 CRAIN HWY. SW , GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a conse dence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tra Due to (or as a consequence of) be Physician/Medical Physician: The law requires that the death certificate as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death the Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed funeral director, page Vital 1 ☐ Yes 2 25. Was case referred to medica examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To of this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending Natural 5 Pending investigation 1 □Yes 2 □No death 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated within 2. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001

State Registrar 5400 OLD COURT ROAD RANDAUSTOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

U6borah

31. Date filed (Month, Day, Year)

ton

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#23apt1, perPHYS, G894, 8/31/09, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 201 M **Physician** 09 06615 ANIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1□M 2/2 F Yrs Delaware 78 Sept. 10 1930 Director 222-20-8933 Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10b. County show 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Stevensville Md. Oueen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21666 300 Bay View Lane Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Counseling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Hamilton Edwin Kruse Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 300 Bay View Lane Stevensville, Md. 21666 Sherri Hollis Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, Md. Chesapeake Crematory 8-4-09 4 □ Dopation 5 □ Other (Specify) 21. Signa are # Funeral Service License 22. Name and Address of Facility capitol Mortuary 20002 1425 Maryland AVe., NE Wash., DC 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between omplications that caus yo not enter the mode of dying, such as cardiac or respiratory arrest ed the death. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Aspiration Pneumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence 4): CA Larynx Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical attending pl for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed page ; 2 **N**o 1 □Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? after death. Division 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifia ပ္ uson who completed gause of death (Item 23a) (Type, Print) 16 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

200	Physici	an	1. Decedent's Name (First, Middle,	ŕ						2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic Examin		ALMA HOPKI  4a. Facility Name (If not institution, GOOD SAMARITAN		r)	1	Town, or	Location of	Death	08	4c. Coun	ty of Death	12:20AM
	Funeral Director		5. Social Security Number  206-20-8602  Usual Residence of Decedent	3. Sex 1 □ M 2 X F	Age (In yrs. last birth	Months		If Under 2 Hours	Min.	8. Date of Birt	h 933	Cou	place (State or Foreign ntry) H CAROLINA
A	Maryland a-f show	tor	10a. State 10b. County MD		10c. City, Town of BALTIM								10d. Inside City Limits X 1 □ Yes 2 □ No
÷	death with the Maryland ims 23a or 28a-f show	ral Director	10e. Street and Number 4519 WEITZEL AVE			10f. Zij	214				10g. Citizen of What Country? UNITED STATES		
7 W 7 W 7	ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, that Prodest Examinat must be notified as	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 □ Yes 2₹ If Yes, Give Year or Dates	? ] No	13. Was Dece If Yes, spe 1 ☐ Yes		ispanic Orig n, Mexican, Specify:	in? (Spe Puerto I	ecify Ye's or No Rican, etc.)	14. R	ace - Ameri lack, White, BLA cify:	etc.
NS, 1	d within 72 hogiene. grene. er than "natu fre Modiesi	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 6th	Education grade completed) College (1-4or	(f	Decedent's Usu Give kind of wo life. DO NOT u LOBBY	ork done d se retired	during most I)	of workin	ng	PRIVATE		
Maryland	S should be filed and and Mental Hygin Is marked other aumatic event, It	To Be (	17. Father's Name (First, Middle, La IRVING BROWN	18. Mother		(First, Middle, )WN	Maiden Surna	ame)					
	1 and 2 sho Health and em 27 Is m		19a. Informant's Name/Relationship TEANDRA T. JENKI		UGHTER 3	Mailing Address	RONDA	ALE AV	E BA	LTIMOR	E, MD.2	21215	•
$\frac{1}{\mu}$ Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		20a. Method of Disposition	ecify)	20b. Place of Decemetery, Woodlay	vn Ceme	RY terv	9	/5/0		20c. Location BALTIMO	DRE, M	
3760,	ate be hysici he bu	dical Examiner	23a. Part 1. Enter the disease, rr or shock, or heart failure. Life or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. PROBA  Due to (or a  b	line.	ELEV						RCTION	Approximate Interval Between Onset and Death
.O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death	3 ☐ Ectopic p 5 ☐ Other (sp		/				Pate of delived	rery Day Year
ords, P.	w requires that the dispersion signed by the should be detached	þ	Part II. Other significant condition:	s contributing to death		he underlying o		en in Part I.	<u>496</u>		obacco use co ′es 2 ☐ No		the cause of death?
al Reco	: The law n cate has be page 2 sh	Completed	PARTIBIDE	MIA								D. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2. No
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, within 24 hours after death, to the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as t	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Solution 1 No Sol								ience 6 🗆 C		ify)
Divis	cal or Atters s after dea al Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Ir	njury - At home, farm etc. <i>(Specify)</i>	n, street, factory	, office		2	28f. Location (5 City or Tov	Street and Nun n, State)	nber or Run	al Route Number,
7	the Hospit in 24 hour the Funera	Medical	29a. Certifier 1X CertifyIng (Check only one)  1 ★ CertifyIng 2 ★ Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination and/	death occurred or investigation	at the tin	ne, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) and date and place	manner as e, and due t	stated. to the cause(s)
	on with			esident		R	e. License	00			29d. Date sign	6/200	
			30. Name and address of person w	o completed cause of arritan HUS	death (Item 23a) (Ty	/pe, Print)	SANT	rosH	042	TAL	. A. F	`	

HODKINS, ALMA B.
Baltimore, Maryland 21215-0036

Anna Haman 8130109 2155 AM

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		-	For State of M	arylan		artment of H tificate of D			Jiene Reg. No. 20	19 27735		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death 2:55 AM  Country of Death  Itimore  9. Birthplace (State or Foreign Country) Maryland  10d. Inside City Limits 1		
	Medic Examin		Anna Elizabeth Herri 4a. Facility Name (if not institution, give street and number)	ian		4b. City, Town, or	Location of Death	August				
- 2			Gilchrict Center for Hospic			Towson						
	Funeral Director		1 D M 2 X E	e (In yrs. Ia 00	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12/29/1	9. Yea <i>r</i> ) 9.	Birthplace (State or Foreign Country)  //arvland		
			Usual Residence of Decedent	r	. T I			12/25/	700   1			
	aryland a-f sho fied at	ctor	,		y, Town or Lo							
	the Ma or 28 e noti	Funeral Director	Maryland Baltimore  10e. Street and Number	Міа	<u>dle Ri</u>	10f. Zip Code			10g. Citizen of Wha	t Country?		
	h with ns 23a nust b	nera	2210 Old Eastern Avenue			21220_			U. S. A.			
<b>'</b>	or iten	by Fu	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Armed Forces?  1 Yes 27		S. 13. V	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)				
21215-0036	within 72 hours after death with the Maryland giene. grethen: the Medical Examiner must be notified at the Medical Examiner.	ted b	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates.			1 ☐ Yes 2 🔀 No	Specify:		Specify:	Vhite		
15-(	72 hou n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa kind of work done do O NOT use retired)	ation uring most of work	ing	16b. Kind of Busin	ess Industry		
212	s should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Med		Elementary/Seconday (0-12) College (1-4 or :	5+)	Homem	•			Own Home	<u> </u>		
	filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam					
Maryland	ould be d Men marke matic		James LaRhue  19a. Informant's Name/Relationship (Type, Print)	10h Maili	na Addraga (Stroat a	Mary	Winkle		Zin Code)			
	and 2 sho Health an tem 27 is		Mark Kraus (Executor of Wil	.1)		Advocate				· · _ ·		
ore,	e 1 an t of He If item or othe	П	20a. Method of Disposition  X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. F	Place of Dispo	osition (Name of matory or other place	-	Date				
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 Donation 5 Other (Specify)			Cemetery		2009	Baltimore	e, Maryland		
Ba	permit. Departr Import. any inji		21. Signature of Funeral Service Licensee			2. Name and Addres Fuzdzinsk 407 Old F		l Home E	A Essex, Mai	cyland 21221		
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the deat				or respiratory arm	est,	Approximate Interval Between		
	nysician/	i (q	Immediate Cause (Final disease or condition		1100 G	40shiss				O set and Death		
-	Medical Examiner		resulting in death)  Due to (or as a consequence of):									
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequ	uence ofj.							
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			resulting in death) Last	a conseq.	acrioc oi).							
68760	ificate ng phy as the	Physician/Medical	IF FEMALE:									
9 X	th cert ttendir or use	ian/I	23b. Was decedent pregnant 23c. If yes, outcome	2 Teta	al death 3	Ectopic pregnancy Other (specify)	у		I	· .		
Box	he dea y the a iched f	hysic	in the past 12 months?  1	at time or t	death 5 L	Other (specify)		1		,		
P.O.	s that t gned b		Part II. Other significant conditions contributing to death I		,		en in Part I.		2. /			
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Records,	e law r e has b ge 2 sl	Completed by						24a. Was a autop perfo	rmed? prio	r to completion of cause of th?		
al R	an: Th rtificate tor, pa	Be Cc	25. Was case referred to medical			26. Pla	ace of Death (Chec		2 No 1 L	Yes 2 □ No		
of Vital	hysici this ce al direc	오				nt 3 DOA Othe	4 ☐ Nursing Ho			Specify) Hospice		
n ol	iding F th. After t	cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	y, Year)	28b. Time o injury	work'		28d. Describe h	ow injury occurred			
The control of the co										r Rural Route Number,		
									the cause(s) and manner stated.			
								fonth, Day, Year)				
0	.1		Kellera Jerula	LANG	)	KI45	356	7	August	30,2009		
	4		30. Name and address of person who completed cause of completed cause of the second se	reath (Iten	n 23a) (Type, I	BUL T	nozwo	MO	2004			
	Sta		31. Date filed (Month, Day, Year)  AUG 31 2009  August	ar's Signa	ture	<b>)</b>						
	Registr	ar	HUU 3 I ZING LEGION	p. 1	in course				<del> </del>			

Amend 23a, per ME 8896 10/1/09 Tr State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Robert L. Hunter 22, 2009 7:38 P. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1308 Merrimac Drive, #201 Adelphi Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral Sex Age (In vrs. last birthday) Hours Months Days Min 157 M 2 □ F Director 520-30-5560 74 Dec. 11, 1934 Wyoming Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Merrimac Drive, #201 20783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. 3 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) Stamp Manufacturer Master Engraver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be NOT AVAILABLE ၉ NOT AVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai 701 Fallsgrove Dr., #303, Rockville, MD 20850 Laurie B. Baturin / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 27 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Funeral Sevice Donnsee Robert A. Pumphrey Funeral Home/Rockville M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cause on each line. **Hypertensive atherosclerotic cardiovascular disease** Immediate Cause (Final disease or condition resulting in death) Physician eseleretic /Medical Due to (or as a consequence of) Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi) Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical the attending philographics and the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1⊠Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 140055927 August 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador Sylvester, M.D., 3001 Hospital Dr., Cheverly, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

■ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		_ State Registrar			Certificate	of Death		Reg. No.	2009	2773
ysiciai		1. Decedent's Name (First, Middle,		TT / N/TT /	TON:		2. Date of De	Day	2009	3. Time of Death
Medica	al -		BRUNSON	HAMIL.				23 Day		1:41 P M
amine	r	4a. Facility Name (If not institution, g FREDERICK MEMO		гт∧т		n, or Location of Death	1		ounty of Death	
neral				e (In yrs. last bi	rthday) If Under 1 Yo	ear   If Under 24 Hrs.	8. Date of Bir		REDERICI 9. Birth	place (State or Foreig
tor		579-50-4699	1 □ M 2 🛛 F	<b>7</b> 5	Yrs. Months Da	ays Hours Min.	8. Date of Bir (Month, Da June 30	<b>,</b> 1934	Sout	h Carolina
	- H	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
	혖	South Carolina Orang	eburg	C	rangeburg					1 □Yes 2 🕅 No
900ce	Funeral Director	10e. Street and Number	9		10f. Zip Co			10g. Citize	en of What Cou	untry?
	a	456 Murray Roa				29115			ed Stat	
	nue	11. Marital Status	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ 1		13. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	)- 14	<ol> <li>Race - Amer Black, White,</li> </ol>	
	<u></u>	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎖 Divorced	If Yes, Give Year or Dates:	NO.	1 □ Yes 2 🔀	No Specify:		S	Specify: B1	.ack
	g	15. Decedent's (Specify only highest	Education	168	a. Decedent's Usual O	ccupation	leina		of Business/Ir	
	n ple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use re	one during most of wor etired)	KING	Appa		nufacturin
	Completed	12			Seamstress			14 : :	P1a	ant
lá	å	17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	<sub>ne (First, Middle</sub> Lee Aike		urname)	
F	<del>ှိ</del>	Peter Brunson  19a. Informant's Name/Relationship	/Type Print)	101	h Mailing Address (Ct	reet and Number or Ru			Town State 7	in Code1
		Kemberly Greene/			575 Birch I	Orive, Orar	ngeburg,	Sout	h Caro	lina 29115
	H	20a. Method of Disposition		20b. Place of	of Disposition (Name o	if I	Date	20c. Loca	ation - City or T	Town, State
		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Belle	ry, clematory or other ville Memo rdens		st 29,		ngebúrg uth Car	
	ŀ	21. Signature on Funeral Service Lic	**	Ga			2 2 -			
		145	<u> </u>	100198_	300 West 1	dres of Fallixey Montgomery	Ave., Ro	ockvi.	ile, MD	20850-280
ı		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that caused ly one cause on each lir	the death. Done.	not enter the mode of	dying, such as cardiad	or respiratory a	arrest,		Approximate Interval Between Onset and Death
ı		Immediate Cause (Final disease or condition resulting in death)	_aCa:	rdiac_A	macat					Onset and Death
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	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ьСо:	ronary .	on: Artery Dis	ease				
	<b>6</b>	,	b. Co:	ronary .	of): Artery Dis	ease				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** : 40 PM bnes 200 /Medical 4c. County of Death Town, or Location of Death Examiner ltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Min. -9685 1 □ M 2 🕶 F **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No imore Director or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21206 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 \_\_Yes \_2 M\_No 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗷 No If Yes, Give Year or Dates: Specify. δ 3 Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working His DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 is marked other than "r ry/Secondary (0-12) College (1-4or 5+) arrollton 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be nformant's Name/Relati permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau 20b. Place of Disposition (Name 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death yeurs coronar Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons guence of ear Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Mr as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Year Por Month Day 4 Pregnant at time of death 5 Other (specify) n signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen ( 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy certificate 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cert 2009 rson who completed cause of death (Item 23a) (Type, Print) 201 Porkivay State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Love Kim Aug 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia **Howard County General Hospital** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, **Funeral** Hours Months Days **Director** Aug 6, 2009 none Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 8150 Randolph Way 21043 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or Specify: FSIQU 1 ☐ Yes 2X No þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within D partment of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magang Light of Elementary/Secondary (0-12) College (1-4or 5+) infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Min K. Kim Soo H. Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Min K Kim Father 8150 Randolph Way #304 Ellicott City, MD 21043 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Aug 12, 2009 Clarksville, Maryland Columbia Memorial Park 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. 5. Let the dilease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail fre. List only one caused line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Box 68760. attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 🗌 Yes 2 200

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, funeral director, page 2 should

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neral Director: A filled in by the fi within 24 hours a To the Funeral I

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2 No 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No

Day

Year

3. Time of Death

Howard

U.S.A.

infant

Birthplace (State or Foreign Country)

9:10 P M

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭XNo 1 npatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending

1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

ND completed cause of death (Item 23a) (Type, Print) Name and address of person

2009

AUG 31

DHMH 17 Rev 1/2001

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma Registrar	aryland / Depa <i>Cer</i>	artment of He tificate of De		ental Hygie Reg.	LUU.	9 27741			
Physicia	an/	1. Decedent's Name (First, Middle, Last)				Date of Death     Month		3. Time of Death			
Medi Exami	cal	Charlotte C. Ko  4a. Facility Name (If not institution, give street and number)	ern	4b. City, Town, or L	ocation of Death	August	29, 20				
Exami	lei	1343 Deanwood Road		Parkv			Baltimore				
Funeral Director		5. Social Security Number 213–44–5056   6. Sex 1 □ M 2 🗷 F   7. Age	(In yrs. last birthday) 85 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes 6/1/1924	9. Bir Co	thplace (State or Foreign untry) Germany			
id now	_	Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	cation				10d. Inside City Limits			
Marylan 28a-f sh otified a	recto	MD Baltimore	Too. Oity, Town of Lot		arkville			1 Yes 2 No			
with the s 23a or 3 ust be no	by Funeral Director	10e. Street and Number 1343 Deanwood Road		10f. Zip Code <b>21234</b>	:	10g	, Citizen of What Co USA				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Fur	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced  12. Was Decedent E Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.	No I	Vas Decedent of Hisp f Yes, specify Cuban, I ☐ Yes 2 🛣 No	Mexican, Puerto F	ify Yes or No- lican, etc.)	(es or No- t, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
15-C	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done dur O NOT use retired)	ion ring most of workin	g 16i	b. Kind of Business	Industry			
212 I within /giene. ner tha		Elementary/Seconday (0-12) College (1-4 or 5-	+)	Accountan	t		Finance	s			
rland The filed The filed The filed The filed The filed The filed The filed The filed	To Be	17. Father's Name (First, Middle, Last) Johnann Neueder		1	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Hacklinger						
Mary of 2 should salth and N n 27 is me er trauma		19a. Informant's Name/Relationship (Type, Print) Anita Bell / Daughter	19b. Mailir 1343	ng Address (Street and B <b>Deanwoo</b>	d Number or Rural od Road,	Route Number, Cit Parkville	y or Town, State, Zi	p Code) <b>34</b>			
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exam prine.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		/2009 200	c. Location - City or Hanover						
Balt permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee DarotaMa	usuall 22	Mary La PO Box	nd Crem 1413,	ation S Baltimo	ervices re, MD	21203			
Physician/	i 5 û	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	the death. Do not ente	-		respiratory arrest,		Approximate Interval Between Onset and Death			
Medical Examiner		resulting in death)  Due to (or as a consequence of):									
a tig	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	consequence oi).								
760 crate be executed physician and sthe burial-transit	edical Examiner	that initiated events C	consequence of):								
760 icate b physi	ledic	d					UI S				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans	by Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yes 9 ☐ Unknown	2 🗆 Fetal death 3 🛚	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year			
IS, P.O  Lires that the signed by all the detact	ed by Pł	Part II. Other significant conditions contributing to death but	ut not resulting in the u	inderlying cause give	n in Part I.			o the cause of death?			
Records, The law require sate has been si page 2 should	Completed					24a. Was an autopsy performed	prior to d? death?	utopsy findings available completion of cause of			
/ital sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	o □ ED/O	Other	e of Death (Check		a [] ov. 10	15 1 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			
n of V ding Phy h. After this funeral d	sate; To	27. Manner of Death  1 Natural 5 Pending  28a. Date of injur (Month, Day	ent 2 ER/Outpatier y 28b. Time of injury	28c. Injury a work?		8d. Describe how in	e 6 Other (Special Office of the Control of the Con	oify)			
Jivision II or Attendi after death Director: A	Certificate;	3 Suicide 6 Could not be	ry - At home, farm, str . (Specify)			8f. Location (Street City or Town, St	t and Number or Ru tate)	ıral Route Number,			
Division of Vital Recc To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	Medical	29a. Certifier (Check (Check only one) (Check only one) (Certifying Physician: To the best of the best	kamination and/or inves	tigation, in my opinion,	, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.			
To the within: To the comple		29b. Signature and title of certifier	o Cen	29c, License r	41957	29d.	Date signed (Mont				
3	1	30 Name and address of persec who completed cause of de	MINICH	arles	#4105	-Balt	mores	109 4021204			
Sta Registi		31. Date filed (Month, Day, Year)  AUG 31 2009  Service  32. Registra	r's Gignature	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Menth ZOO9 KRAUS **Physician** 1855 PM LUGENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SPRINGS SUBURBAN HUSPITAL SILVER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 Ø M 2 □ F 170-34-035 66 MAR 8, 1943 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at SILVER SPRINGS 1 ✓ Yes 2 ☐ No MONTGOMERY Directo 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 19600 CRYSTAL ROCK DR. 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No It#es, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No Completed by Specify. Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced "natural", er than "natur, 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MASON BRICK 8TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES KRAUS LENA MILLER ဥ permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 Is marl any injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19600 CRYSTAL ROCK DR. #23 SILVER SPRINGS MD MONICA KRAUS DAU 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMMHSBURG CREM. SPT. 1,2009 SMITHSBURG, MD. 22. Name and Address of Facility CARY L. ROLLING FUN! HOME 110 WEST 50 RT ST PROJECT MD 21701 21. Signature of Funeral Service Ligenses Kollis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** RESPILLATORY Kulurt -10 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC HON-SMALL CELL LUNG CANCOR YRS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 🗹 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I funeral director, page 2 s autopsy 2 1 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) DD\$ 6816\$ 8/26/09

State Registrar 30. Name and address of person who completed

KIMBERLY B. ZUZAK

BEORGOTOWN RD. SILVER SPRINGS MD 20874

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

8600 060

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Μ. Knight August 25, 2009 8:15 P. M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Marley Health & Rehab. Center Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours 1 □ M 2 🛛 F 88 245-07-0095 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🛣 No Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21060 USA 9 Southfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 Tho 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 →No If Yes, Give Year or Dates Specify Specify: white 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) M.V.A. Drivers Test Administrator

Ely

133 Thomas Rd. Glen Burnie MD 21060

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Butler

20c. Location - City or Town, State

28a-f show ir than "natural", or items 23a or 28a-f show 72 hours after death Baltimore, Maryland 21215-0036 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r 1 and 2 s Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr For State Registrar

Sarah

10a. State

11. Marital Status

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Susan G. Baierlein/duaghter

McIntyre

Charles

Director

Funeral

<u>۾</u>

Completed

Be

ပ

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

Physician /Medical Examiner

attending physician and for use as the burial-transi P.O. been signed by the should be detached of Vital Records, page 2 has After this certificate ospital or Attending Physician: 1 hours after death.

Leraral Director: After this certifical by filled in by the funeral director, pa Division within 24 hours a

To the Funeral D Hospital completely

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 828/2009 Glen Burnie, MD Glen Haven Mem Prk 5 Other (Specify) 4 □ Qonation 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 21. Signature 421 Crain Hwy SE Glen Burnie MD 21061 M01364 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □ Yes 2 🖾 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2⊠No Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🔼 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinari On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D57028 August 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Aditya Chopra, M.D., 600 Ridgely Ave., Suite 231, Annapolis, Maryland 21401

Registrar's Signatu

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othen any Injury or other traumatic event Physician /Medical Examiner law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

r 28a-f show notified at

"natural", or Items 23a or edical Examiner must be

Hygiene. other than "natura ent, the Medical E

marked other

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending p signed by the a has s certificate has lirector, page 2

To the Hospital or Attending Physician: The s after death.

I Director: After this of in by the funeral d within 24 hours aft To the Funeral Di completely filled in

	1 ☐ Yes 2 🛣 No 9 ☐ Unknown		4⊟Pregnant at time or d 9⊟Unknown	leath 5∟Other (8	specity)							
	ii. Other significant con Chronic Bro		ntributing to death but not res Ctasis	ulting in the underlying	cause given in Pa	art I.		use contribute to the cause of death?  ☐ No 3 🏋 Probably 4 ☐ Unknown				
							24a. Was an autopsy performed? 1  Yes 2  X No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
	Vas case referred to me xaminer?	edical	26. Place of Death (Check only one)									
	X Yes 2 No	Н	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D	Nursing Home	me 5 🛱 Residence 6 □Other (Specify)						
1	27. Manner of Death  1  Natural 5  Pending 2  Accident investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	284 2 🗆 No	3d. Describe how injury occurred					
		ould not be etermined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28	f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)				
29a.			sician: To the best of my kno ner: On the basis of examina and manner stated.					) and manner as stated. d place, and due to the cause(s)				

29c. License number

D0027985

29d. Date signed (Month, Day, Year)

August 24, 2009

State Registrar

31. Date filed (Month, Day, Year) AUG 3 1 2009

29b. Signature and title of certifier

William H. Selvemm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William H. Silverman, M.D. 1201 Seven Locks Road, Suite 111, Rockville, Maryland 20854 \$2. Registrar's Signature

Box 68760. P.O. of Vital Records. Division

/Medical Examiner **Funeral Director** death with the Maryland 23a or 28a-f show traumatic event, the Medical Examiner must be notified at or items Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
unt: If item 27 Is marked other than "natural", or ite Baltimore, Maryland 21215-0036 permit. Pages 1 and 3 Department of Health Important: If item 27 I any injury or other tra once. **Physician** /Medical Examiner the Hospital or Attending Physician. The law requires that the death certificate be executed ending physician and use as the burial-tran within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie M.D. 0101243203 and address of person who completed cause of death (Item 23a) (Type, Print) 20892 HANS ACKERMAN 10 CENTER DRIVE, BETHESDA, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

AUG 3 1 20

09-06561 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death Reg. No Registrar Middle,Last) 2. Date of Death Time of Deat 1. Decedent's Name (Firs Physician/ Month Day August 22, 2009 0100 hrs Divid **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore St Agnes Hospital Date of Birth (MM/DD/YYYY)Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex **Funeral** Director 21 22 1988 1 VM 2 Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location 10a State 10b. County 1 VYes 2 or items 23a or 28a-f show must be notified at once. Maryland Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 1 Yes 2 No specify: 3 Widowed If Yes. Give Yea Divorced traumatic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) tant: If item 27 is marked other than or other traumatic event, the Madical Home In provement 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last Davia Be or Rural Route or Town, State, Zip Code) 19b. Mailing Address 20b. Place of Disposition (Name of cemetery crematory or other place) Important: injury or oth Memorial Other Specify 21. Signature of Funeral Service Licenses pproximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical XX AMENDED #28e Per ME G894 8/31/09 JH ed by the attending physician detached for use as the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Ectopic pregnancy Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? 1 1 Yes this certificate ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica of Vital Be examiner? Other<sub>4</sub> Other Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ဥ 1 V Yes No 28a. Date of Injury (Month, Day Year) Aug 22, 2009 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury Certification: Subject shot 0014 hrs Natural Division Yes 2 V No Il Director: Pending Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) 600 Yale Avenue, Baltimore, MD Steps 4 V Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 22, 2009 O.C.M.E. **OCME** Name and address of person who completed se of death (tem 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD 31. Date filed (Month, Day, Year) State AUG 3 1 2009 Registrar

AVIZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 ugust /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deat Examiner amavitan Disa saltimore Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. Maryland 1 M 2 N Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show the Medical Examiner must be notified at 1 Kes 2 □ No Director eltimore 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or items 29a
any injury or other traumatic event, the Wedien Event by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Specify. Specify: Iac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic tomemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hlohonzo မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Himore 21. Si nature of Funeral Service Licensee 82 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nobable disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation ours after death. neral Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560/Loch Kaves Blod Sel-408, eidel MI)

Registrar DHMH 17 Rev 1/2001

State

Edward 31. Date filed (Month

Day, Year)

32 Registrar's Signature

When Grown as Marceni, Radul
Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** August RAOUL 8:10 + M MARCONI 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Sumuking Sind: Huspita 5. Social Security Number Horare If Under 24 Hrs. If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 214-38-2908 1**∑**M 2□ F 70Yrs. Director 11-20-1938 ITALY Usual Residence of Decedent hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic evant, the Madical Examinar must be notified at MD BALTIMORE RASPEBURG 1 ☐ Yes 2♥ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5127 McFAUL ROAD 21206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2 **X**No 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natuary injury or other fraumatic and increase." Elementary/Secondary (0-12) College (1-4or 5+) SELF ENTREPRENEUR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) NAZZARENO MARCONI **VERA** (DORIA) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSEMARY MARCONI/WIFE 5127 McFAUL ROAD BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 8-31-2009 TIMONIUM, MD DULANEY VALLEY MEMORIAL 14 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, 21237 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Massive bastrointetuna **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cost winterstand Bleed in past due to Hen 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy 2 **12** No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 VNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) , Mai 31. Date filed (Month, Day, Year) AUG 3 1 200 32. Registrar's Synature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar 9000

FRANKLZ 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



SQUARE

myryam Molina

09-06560 UNK UNK

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State of Maryland	/ Department	of Health and	l Mental Hygiene

2009 27750

		1- For State Certificate of Death Reg. No.							
Physicia	an/	Decedent's Name (First, Middle,Last)				Date of Death     Month Date	ay_ Year	3. Time of Death 2302 hrs	
ledical Exami		Myryam Molina			August 21, 2				
		4a. Facility Name (if not institution, give str	eet and number)	4b. City, Town, or	Location of Death		4c. County of Deatl	י	
		Johns Hopkins Hospital  Baltimore  5 Social Security Number 16 Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 if Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or							
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth			_	MM/DD/YYYY) 9. Bii Forei	thplace (State or	
Director		470-34-7514 1 M	2 XF 89	Yrs. Months Days	s Hours Min.	May 20.	1920	gnGuatemala puntry)	
	ŀ	Usual Residence of Decedent							
any	1	10a. State 10b. County	10c. City, Town o	or Location				10d. Inside City Limits	
nd thow ce.	_							1 Yes 2 No	
Aaryland 28a-f show any 1 at once.	윙	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	intry?	
rith the Maryland 23a or 28a-f sho notified at once.	Director								
ith th		11. Marital Status 12	. Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? ( St	pecify Yes or No-	14. Race - Ame	rican Indian, Black,	
death w or items must be	uneral	1 X Never Married 2 Married	Armed Forces?	If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	White, etc.		
o, or	╙	3 Widowed 4 Divorced If Y	Yes 2 X No	1 X Yes 2 No	specify: Gua	temalan	Specify:	white	
ural'	<u>ē</u>	15. Decedent's Education (Specify only h	ohest grade completed) 16a. D	Decedent's Usual Occupa	tion (Give kind of v	work done	6b. Kind of Business		
2 hou "nat	ş	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life	. DO NOT use reti	ired)			
36 hin 7 than	Completed	12	4	nursing			healthc	are	
d wit	팃	17. Father's Name (First, Middle, Last)			18.Mother's Name	e (First, Middle, Mai			
21215-0036 vald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Lisandro Molina			Delia	a Castell	anos	30000000000000000000000000000000000000	
21; buld build b	2	19a. Informant's Name/Relationship (Type	Print ) 19b	. Mailing Address (Stree	et and Number or I	Rural Route Number	er, City or Town, Stat	e, Zip Code) unk	
MD d 2 sho Ath and n 27 is aumati		Josh Kades/attorne	у						
		20a. Method of Disposition		of Disposition (Name of ce pry or other place)	metery,	Date 2	20c. Location - City o	r Town, State	
ages other other		1 Burial 2 Cremation 3	Removal from State	bry or other place)		Į			
Baltimore, bermit. Pages I ar Department of Hee Important: If ite		4 X Donation 5 Other Specify:	Ald.	22. Name and Addres	s of Facility	1 (55 17	D 154	Church	
Balti permit. Departm Imports		21. Signal Training Tryice Sice of	rirector	State Anat	-		Baltimore	e Street	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval							
/Medical	8	failure. List only one cause on each line.  Death							
xaminer			to (or as a consequence of):						
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	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death 1 ast							
ted Insit	Ex	events resulting in death) Last Due to (or as a consequence or):  d.							
760, icate be executed physician and the burial - transit	cal		MENDED						
760, icate be a physicia the buria	Medical		3c. If yes, outcome of pregnancy				23d. Date of delive	erv	
876 ifficat ng ph		23b. Was decedent pregnant in the	Live birth 2	Fetal death 3	Ectopic pregn	ancy	Month	Day Year	
Box 687 death certific the attending y	Physician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)							
BOy death the att	hys	1 Yes 2 V No 9 Unknown	Unknown						
Records, P.O. Box 68' The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:		Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause	given in Part I.	1		to the cause of death?	
ires the signer is the d	d by					1 Yes		obably 4 Unknown	
ords, R w requires s been sig should be	Completed					24a. Was ar autopsy	24b. Were	autopsy findings available completion of cause of	
e law e has ge 2 sl	mp					perform 1 ✓ Yes 2	ned? death'	?	
		25. Was case referred to medical 26.Place of Death (Check only one)							
ician ician s cert recto	Be	examiner? Hos	oital: 1 Inpatient 2 V ER/O		Other		tesidence 6 Oth	ner:	
ion of Vital Records, tending Physician: The law requir leath tor: After this certificate has been s rethe funeral director, page 2 should I	은	1 ✓ Yes 2 No 27. Manner of Death			ury at Work?		ow injury occurred		
n of iding Pl	o E E	1 Natural 5 Pending	(Month Day Vear)	6 hrs 1	Yes 2 ✔ No	Pedestrian st	ruck by auto		
ivisior or Attend after death Director:	cat	2 Accident Investigation	28e Place of Injury - At home fa	arm street factory office	building, etc.	28f. Location (St	reet and Number or	Rural Route Number, City	
Division pital or Attendiours after death reral Director: /	Certification:	Suicide 6 Could not be or Town, State)							
iou spi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the Hos within 24 h To the Fun completely	Medical	one) Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						the cause(s)	
To To		and manner stated.					29d. Date signed (/		
	_	110 - 1- M.	0.0	O.C.M.E.			August 22, 2009		
		mengente III	ploted source of dooth (Hom 225)						
		30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201							
	tate	31. Date filed (Month, Day, Year)	14 automotive Communication						
Regis			Sever D. A	parked					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 23, 2009 **Physician** 5:35 AM M Lillian M. Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Homewood of Williamsport Williamsport If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Oct 2, 1923 233-38-8826 85 Illinois Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ral", or items 23a or 28a-f shov Evaluituers, ust be notified at MD 1 □Yes 2√√ No Washington Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18928 Dover Drive by Funeral 21742 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Exat. The Once. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 🕅 No Specify Specify: White 31√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 presser dry cleaners 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Korchmaros 2 Sopha Bor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Miller/son 18928 Dover Drive Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Ignoture of Funeral Service I 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cuse (Final disease or condition resulting in death) **Physician** years Alzheimers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaving to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Atheroscleratio Heart Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nursing Home, 16505 Virginia Avenue Cynthia Kuthner-Sands, no Nomewood Williamsport, Maryland 21795 31. Date filed (Month, Day, Year) AUG 31 2009 32. Registrar's Signature

and manner stated

thea Kutther Sand, NO

parked

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) Aupust 24, 2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day August Year **Physician** 1005A 26 2009 BRENDAL MCKOY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2907 BRIGHTON STREET BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex **Funeral** Director 64 NEW JERSEY 216-42-9345 MAR 29 1945 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 28a-f show 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 23a U.S.A. 2907 BRIGHTON STREET 21216 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXI

If Yes, Give
Year or Dates: Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XXNo Specify. Specify: ⋛ BLACK 3 ₹ Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC INDUSTRIAL ENGINEER 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ADELL ROBERTS GOODIN unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 2907 Brighton Street, Baltimore, Maryland 21216 Sheila Smith/Daughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of Important: If it any injury or o XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 09-01-09 BALTIMORE, MARYLAND 21. Signature of Ingral Statute 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE uplur 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebrovascular Thrombosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No signed by the a o. 9 ☐ Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Hypertonsum 1 Yes 2 No 3 Probably 4 Unknown Completed Diabates Mallitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 No 1 ☐ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a the Hospital 29a. Certifier 12 \_\_ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \_\_ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 28 H45931 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEDOTA h BW 5400 OLD 5400 OLD COURT RD RANDAUSTOWN MD 32 Registrar's Signatu Registrar

09-06532 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Antonio L. McBride State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3 Time of Death Medical Examiner Lamont Mc BRIDE NTONIO 0929 hrs August 21, 2009 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Foreign Months Days Min. Hours Director tor. 20 216-69-8012 M 2 F Yrs Usual Residence of Decedent 10a. State 10c. City. Town or Location MD. GERMANTOWN MONTGOMER items 23a or 28a-f show ust be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country CHURUBUSCO 20874 USA 19339 Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. 1 Never Married 2 Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Married Yes Specify: BLACK f Yes, Give Year 3 Widowed 1 Yes 2 No specify: 4 Divorced ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 NA 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ANTONIO L. Mc BRIDE, Jr. Jenee Battle Be 19a. Informant's Name/Relationship (Type, Print ) Jenee Battle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Sours Donation 5 Other Specify 21. Signature of Funeral Service License of 110 WOST SO WAY SI FREDERKR Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure List only one cause on each line. /Medical Bronchiolotis and early acute pneumonia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) Cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical XUNPENDED burial. AMENDED as noted 23a, PII, 27, perME, G898 12/17/09 TT 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congenital microvillus inclusion diabetes (by 24a Was an history), status post transplant of liver, pancreas autopsy

If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian, Black, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 08 74 19339 CHURUBUSCO LANE GERMANDUM Med Aug 29, 2001 GERMANTOWN MA Between Onset and Death Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicistely filled in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No and small bowel 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 ✔ Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA 1 Yes 28a. Date of Injury (Month, Day,Year) 27, Manner of Death 28b. Time of Injury 28c, Injury at Work? 28d Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident 2 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 1 within 2 To the 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2009 Name and address of person who completed callse of death (Item 23a) Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Date filed (Month, Day, Year, AUG 3 1 2009 32. Registrar's Signatur Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 5:30 a M 26, 2009 ETHEL MAE MARSH TITIT, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE ANATOMY BOARD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Vear) Min. Months Days Hours 1 M 2 TX F 240-36-5711 June 5, 1924 S.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show 1X Yes 2 □ No Director D.C. Washington death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 United States 20020 23a 1712 St., S.E. event, the Medical Examinar must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: Black þ 3 ₩ Widowed 4 Divorced natura!" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Domestic t of Health and Mental Hygie If Item 27 is marked other to or other traumetic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Hannah Williams ပ George Buckman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 DC St., SE Wash., Vivian Marsh-Deloach/Daughter 1712 28th Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it eny injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, Md. 8-6-09 Chesapeake Crematory: 22. Name and Address of Facility Capitol Mortuary 21. Sign June of Funeral Service Licensee any in 20002 1425 Maryland Ave., NE Part 1. Enter the disc as 2, or complications that caused the deat shock, or heart fails re. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final a ANTENOSCIENTIST CANDIOVASCO **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) be executed burial-tran Due to (or as a consequence of): 68760, attending physical for use as the b requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the a detached f o 9 Unknown signed be deta Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by nt lutin Dependen 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 - No certificate Sepsis Vital 1 ☐ Yes 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Division or Attending 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours after deat To the Funeral Director; 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 29a. Certifier 1🚅 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only anel the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie veenssory Rd Hightsville Wil 2020/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 42034 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 3 1 2009 Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. AMEND TITEM#7,8, & 9FH, G894,87,31709, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10:23 AM 2009 August Thomas McCoy Sheldon 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Essex 1700 Old Eastern Avenue Baltimore Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Days Months Hours 1**X** M 2 □ F 1/29/1933 Yrs. Pennsylvania 76 219-28-7924 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ XJo Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21221 S. A. 1700 Old Eastern Avenue 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 🗆 No 1 ☐ Yes 2 No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorene Gallagher Albert Ruel McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Brother) 16332 Bawtry Court Bowie, Maryland 20715 Paul McCoy 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paltimore City, Maryland Bayview Crematory ature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final suddent e -Va disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Yea Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Examine attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical nse y signed by the a d be detached fo þ icate has been siç , page 2 should b Completed Physician: director, Be Certification: To this funeral c After t

Physician

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f shov

Director

Funeral

ð

Completed

Be

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item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercises must be rectified at

72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

らも

Medical

State Registrar

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) joucher Blud. Towson 1312 M - TUN

6 ☐ Could not be determined

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	State of Maryland / Dep	eartment of Health and Nertificate of Death		and the state of
		Registrar  1. Decedent's Name (First, Middle, Last)	er linicate or Death	Reg. No.	3. Time of Death
Physic		7			2009 Year 4:00 PM
. /Medi Exami		Donald D, McGee  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	· -	c. County of Death
LAGIIII		8071 Longbranch Terrace, T2	Glen Burnie		Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year 8-8-1940	9. Birthplace (State or Foreign Country) OHIO
Director		286-36-8681 1⊠ M 2□ F 69 Yrs.		8-8-1940	OHIU
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
Maryl f sho	ţō	MD Anne Arundel Glen Bur	rnie		1 □Yes 2 🛣 No
r 28a	irec	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
h with	a D	8071 Longbranch Terrace, T2	21061		USA
ems s	iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36 after or it	Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No ☐ If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: white
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Evaniner must be notified at	ed b	15 Decedent's Education 16a Dec	edent's Usual Occupation	16b.	Kind of Business/Industry
21215-0036 d within 72 hours aft rgiene. er than "natural", or ,	plet	(Specify only highest grade completed) (Giv	re kind of work done during most of work DO NOT use retired)		
212 d with giene	Completed by Funeral Director	Elementary Secondary (0-12) College (1-4or 5+)	Draftsman		Iron Industry
nd ne file	Be (	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide ce Victory	
Maryland Id 2 should be file Ith and Mental Hy 27 is marked oth traumatic event	မ	Ray Edward McGee			
Mar 12 sh h and 7 is m			lling Address (Street and Number or Ru ${ t Eastham}$ Ct ${ t \#22}$ , Cr		
em 2		20a Method of Disposition 20b. Place of Dist	position (Name of		Location - City or Town, State
ages ant of tt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place) ematory 8/28	3/2009 Cat	onsville MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinal must be notified at any injury or other traumatic event, the Medical Evantinal must be notified at any once.		4 Jonator Statie (Specify)	22. Name and Address of Facility Kirkley-Ruddick Fu		D 7
Bal permi Depar Impor	10	M01364	Kirkley-Ruddick Fu 421 Crain Hwy. SE;	Glen Bur	nie, MD 21061
		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Atherosclerotic (	ardiovascular Di	sease	Onset and Death
/Medical		resulting in death)  Due to (or as a consequence of):			
Examiner	Ι.	Sequentially list conditions, If any leading to immediate  b			
Ted V	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
) and land	Exal	that initiated events resulting in death) Last Due to (or as a consequence of):			
68760, Criticate be executed by physician and as the burial-transit	dical	d			
68 rtifica ng ph as th	Vedi	IF FEMALE:			Ø 1 × 1 × 1
Box 6: death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death	B ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
" D 0 D	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		
hat the deby		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
Vital Records, F sician: The law requires that certificate has been signed irector, page 2 should be det	d by			1 ☑ Yes	2 No 3 Probably 4 Unknown
cord w requir	Completed			24a. Was an	24b. Were autopsy findings available
The law	l E			autopsy performed 1 □Yes 2 □	
	0	25. Was case referred to medical	26. Place of Dea	th (Check only one)	10,100 ==115
<u>~</u> ~ ~ ¬	To B	examiner?  1   Yes   2   No		ome 5 Residence	e 6 Other (Specify)
	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	y Work?	28d. Describe how in	ijury occurred
Vision Attending ar death. ector: Afte	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home farm	M 1 Yes 2 No	28f Location /Street	and Number or Rural Route Number,
Division or Attending after death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	Street, factory, office	City or Town, St.	ate)
Divisit To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and plac	, and due to the cause	e(s) and manner as stated.
n 24 h n 24 h ie Fui sletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	urred at the time, date	and place, and due to the cause(s)
To the within 2 To the comple	×	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		Duly Junia	201412		2171109
7		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	21661	
d		31. Date filed (Month, Day, Year)  32. Registrar's Signature	tot ( lan	51041	
Si Regis	tate trar	31. Date filed (Month, Day, Year)  AUG 3 1 2000  32. Registrar's Signature	Mad		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** G .. August 26, Mauney Janet 2009 20:25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3210 N. Leisure World Blvd. #402
7. Age (In yrs. last birthday) Montgomery

9. Birthplace (State or Foreign Country)

939 Washington, D.C. Silver Spring
If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, ) August 12, Year) 1939 **Funeral** Hours Min. 1 □ M 2**X** F Months Days 217-36-5001 70 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County ed other than "natural", or items 23a or 28a-f shore event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20906 3210 N. Leisure World Blvd. #402 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Manager 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be 77 is marked of traumatic ever Bernice Madeline Elder Unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 8903 Reichs Ford Road, Frederick, Maryland 21704 Teresa Marie Nixon / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 28. August 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc. 4 □ Donation 5 □ Other (Specify) 2009 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Funeral Prvice Licensee Approximate Interval Between Onset and Death Years 23a. Part If Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transli Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Dav Year 5 ☐ Other (specify) signed by the a 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension, Hyperlipidemia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown has been signed by a should by Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate ha rector, page 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🂢 Residence 6 ☐ Other (Specify) 1 XYes 2 □ No Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation I Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

Deena Shapiro,

eena

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Signa

M.D

29c. License number

D35336

10810 Connecticut Avenue, Kensington, Maryland 20895

29d. Date signed (Month, Day, Year)

August 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06601 State of Maryland / Department of Health and Mental Hygiene Ralph Dewitt McCloud Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 23, 2009 1100 hrs **Medical Examiner** DeWitt McCloud Ralph 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/ABaltimore 2114 Maryland Avenue Apt #2 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Wash. If Under 1 Year If Under 24Hrs. 7. Age (in yrs. last birthday 6. Sex 5. Social Security Number **Funeral** Days Hours Months D.C. Director 10/27/1942 1XXM 2 66 214-42-2791 Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location 10b. County ıny 10a. State 1 X Yes 2 No 28a-f show Baltimore . Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Trant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21217 2114 Maryland Avenue 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status Was Decedent Ever in U.S White, etc Armed Forces? Never Married 2 Married Black Specify: Yes 2 X No specify 4 X Divorced Yes, Give Yea Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) United States Army Chemist 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian V. Scott Be D. McCloud Talmadge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20018 Channing Street, Washington, D.C. McCloud Rodney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 9/11/2009 Cheltenham, Cheltenham Vet. portant: Donation 5 Other Specify. Estep Brothers Funeral Service, PA 21. Signeture of Funeral Service Lice 300 Eutaw Place. Baltimore Approximate interval ot enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Part I. Enter the disease, or complications that caused the death. failure. List only one cause on each line. Between Onset and Physician Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit that the death certificate be executed Physician/Medical UNPENDED **AMENDED** ysician a 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy attending phys for use as the b Year Day 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o No 3 Probably 4 ✔ Unknown ģ σ. Completed Records, 24b. Were autopsy findings available 24a. Was an this certificate has been I director, page 2 should prior to completion of cause of autopsy death? performed? 1 🗸 Yes Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be Other<sub>4</sub> Residence 6 V Other: Scene Hospital: Nursing Home 5 DOA Inpatient ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Yes 2 No ✓ Natural Pending the . 28f. Location (Street and Number or Rural Route Number, City 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc in by or Town, State) 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1

Hospital or Attending Physician:

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

and address of person who completed cause of death (Item 23a)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 24, 2009

Medical

State Registrar

29b. Signature and title of certifier

Melfssa Brassell, MD

						Certificate of	Death	F	Reg. No.	~ _	
			1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	ith 06 Day	Year	3. Time of Death
	Physici /Medi		Wallace Loyd	Pannier				August			11:45 AM
	Examir		4a Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or Lo	cation of Death	4c. County	of Deeth	
1	ZAGITILI		Glade Valley	Nursing &	Rehab Ce	enter	Walkersvi	11e	Fre	deric	k
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last	birthday) If Under 1 Year		8. Date of Birth (Month, Day	Year)	9. Birthpl Coun	ace (State or Foreign
	Director		528-30-4619	1 <b>∑</b> M 2□F	81	Yrs. Months Days	Hours Will.	Aug 22,		Utah	
	*	'	Usual Residence of Decedent								
	ylen how		10a. State 10b. County			own or Location				10	Od. Inside City Limits
	Ma	Š	MD Frede	erick	F	rederick					1 □ Yes 2√□ No
	h # 28	Director	10e. Street and Number		*	10f. Zip Code			10g. Citizen of N	What Coun	try?
	uth with the Marylen 23a or 28a-f show	0	142 Fairview A	venue			21701		US	A	
	within 72 hours after death with the Marylend ene. than 'raturel', or items 23a or 28a-f show ha Madical Examiner mast be notified at	Funeral	11, Marital Status		edent Ever in U,S.	13. Was Decedent of	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-		e - America	
	or its	Ē	1 ☐ Never Married 2 Marrie	Armed Fo	2 No	1 ☐ Yes 2 No		rticali, etc.)			
	urs a	ğ	3 Widowed 4 Divorced	If Yes, Gir Year or D	ve Pates: 145-48	3 Thes 281 No	<i>Зреспу.</i>		Specif	v: WII	ite
	n 72 hours a "natural", c edical Exa	Completed	15. Decedent	s Education	10	Sa. Decedent's Usual Occu (Give kind of work done	pation	unk	16b. Kind of B	usiness/Ind	lustry un
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3	ould be Mentel arked o	2	Karl Arthur	Pannier			Vera S	oderber	g		
	E E E		19a. Informant's Name/Relationsh	nip (Type, Print)	1	9b. Mailing Address (Stree	t and Number or Rur	al Route Numbe	er, City or Town	State, Zip	Code)
	4 7 5 6 7 5 6 6 7 5 6 6 7 5 6 6 7 5 6 6 7 5 6 7		Betty Pannier/	spouse		142 Fairview	Avenue F	rederic	k. MD	21701	
ĵ	- I P E	1	20a. Method of Disposition		20b. Place	of Disposition (Name of		Date	20c. Location		wn, State
2	40 0		1 Burial 2 Cremation		State	itery, crematory or other pla	ice)				
Dalumore,	permit. Pag Department Important: It any injury o		4 ☑ Donation 5 ☐ Other (Sp. 21. Signature ← Funeral Service L	1	11.	22 Name and Addr	ess of Facility				= = =
	Depa mpo any i		Ronald S	, Wade	litector	22. Name and Addr State Anat	omy Board	655 W.	Baltim	ore S	treet
			/xmn//	////	INC.	Baltimore					
		ľ	23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	caused the death. Deach line.	to not enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
F	Physician									Disea	
, A.	/Medical Examiner		Immediate Cause (Final disease or condition	,	EVERE	END STAC	E Chronic	. obstri	tive ful	M300 A	ZOVES
	LAMITIME		resulting in death)	-						4 40	ZOVI.
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	scute ind trens	=		<b>-</b> b	Due to (or as	a consequence of):				-	ΖΟγι
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	e a nie	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b							2041-
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DIVISION OF VITAL RECOLUS, F.O. DC	Physician: The law requiras that tha death or this certificata has been signed by the attendinal director, page 2 should be detached for un	Certification: To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other algnificant condition  Congestive Samples of Congestive Samples Sample	Hospital: 1 28a. Date (Mon ation on the build)  2 Physician: To the Examiner: On the beautiful on the building Physician: To the Examiner: On the building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To the Building Physician: To	Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as  Due to (or as	a consequence of):  a consequence of):  a consequence of):  g in the underlying cause g  To Coll Full  ATRIAL Full  Outpatient 3 DOA O  Outpatient	26. Place of Deather: Nursing Houry at onk? Yes 2 No	23b. Did 1 11 24a. Was performent of Check only of Check only of Check only of City or Tour and due to the red at the time,	tobacco uae co Yes 2 □ No an autopsy med? Yes 2 No one) dence 6 □Ot how injury occu	ontribute to 3 Proid Pro	or the cause of death bably 4 □ Unknow  ere autopsy findings ailable prior to mpletion of cause deeth? □ Yes 2 □ No  (y)  at Route Number,  tated. or the cause(s)

State Registrar

Zamas 31. Date filed (Month, Pay, Year) AUG 3 1 2009

S. GRISSOM MID 1475 TANEY AVE \$204 FREDERICK, MB. 21702 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Many) Gay 3'ear) 2009

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature

9701 Veirs Drive, Rockville, MD 20850 Registrar's Signar

ares h

29c. License number 021726 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CARL VINCENT REEDY August 30, 6:47P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towosn 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XXM 2 □ F Months Days Hours Min. Aug 29, 1928" Marviand 220-20-5985 81 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1XX Yes 2 ☐ No Baltimore Maryland None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 21234 USA 2705 Rosalie Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
XX Yes 2 \sum No Korea Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes XXX No Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Firefighter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herman Reedy Mary Alice Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V Reedy Wife 2705 Rosalie Avenue Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
GreenMount Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 9/1/09 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral profice Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Filysician, disease or condition resulting in death) Medical Due to (v as a conse Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box ( Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) (6 \(\sum \) မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1.X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the basis of my line who go death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) R149194 31,2009 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Choslin Gran MD 21204 Towson.

State Registrar (Mosth, Day, Year) UG 3 1 2009

7

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 12:13 PM A. Stone Hazel August 27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center Baltomore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√√ F Director MD APRIL 3, 1917 214.20.0037 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Items 23a or 28a-f show 1 ☐ Yes 2√C No Director DUNDALK BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21222 3455 McSHANE LANE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📆 🕷 o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2/√XNo Specify. WHITE ģ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ MINNIE ELLEN MORGAN WILLIAM BENSON BEADENKOPFF 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2455 McSHANE LANE, DUNDALK, MD 21222 SON ERNEST ELWOOD STONE, SR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 xx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ISEP. 1, 2009 BALTIMORE, MD 21. Signature of Funeral Service Toens FINK FONERAL HOME, P.A. 426 CRAIN HWY. SW., GLEN BURNIE, MD masing

Physician /Medical Examiner

an cal ner

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed.

- 1	h. William	11111	,				
	23a. Partt. Enter the disease, or com shock, or head failure. Lis only Immediate Cause (Final disease or bondition resulting in tleath)	a. Hyperkalen	110		or respiratory arrest,		Approximate Interval Between Onset and Death Unours
ia e	Sequentially list conditions, if any leading to immediate	b. Metabolic i	Audo				Shows
xamin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Acut Rev	ral F	acture			24 hours
dical E	(	_ d					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	3 ☐ Ectopic 5 ☐ Other (			23d. Date of de Month	livery Day Year
占	Part II. Other significant conditions of	contributing to death but not resulting in t	he underlying	cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
q p	Congestive	Heart Failure			1 ☐ Yes	2 No 3 ₽	robably 4 Unknown
plete	Hypert	Heart Failure LENSION		To .	24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
S	(				performed	? death? No 1 ☐ Yes	s 2 × No
Be	25. Was case referred to medical examiner?				ath (Check only one)		
	1 Yes 2 No	Hospital: 1 XInpatient 2 ☐ ER/Outp	atient 3 🗀 [	DOA Other: 4 Nursing H	fome 5 ☐ Residence	6 ☐ Other (Spe	ecify)
ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	n	ne of ury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	
Medical Certification: To	3 Suicide 6 Could not b 4 Homicide determined		n, street, facto	ory, office	28f. Location (Stree City or Town, S	t and Number or R late)	ural Route Number,
edical		nysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.					
Ž	29b. Signature and title of certifier		2	9c. License number		Date signed (Mon	
	1 tate Che	√D-0.		12FS-000	1	Cult 277	2009

Registrar
DHMH 17 Rev 1/2001

State

Eastern

Avenue Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

Kate Elfvey D.O.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 6:09AM UNE SKOWRUNSKI 2009 AUGIUS7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL ARBOR If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2\XX Months Days Hours Min. UNIONTOWN, PA Director 185.18.0110 MAY 30, 1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County ral", or items 23a or 28a-f shov Examiner must be nutified at 1 XXVes 2 □ No Director BALTIMORE MΓ 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 4115 FAIRHAVEN AVE. 21226 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ No Specify. Specify: WHITE 3 Widowed 4 □ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 FOOD SERVICE BALTIMORE CITY SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked c traumatic ever EDITH BAILES EDGAR O'NEAL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 69 PAR VIEW RD., ROTUNDA WEST, FL 33947 EDWARD C. ARNOLD SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN CEMETERY AUG.28, 2009 GLEN BURNIE, MD re f Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. r c implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t on y one cause on each line. Approximate Interval Between Onset and Death Enter the dise or heart failure Immediate use (Final disease or condition resulting in de h) SEPTICEMIA Physician /Medical Due to (or as a consequence of): Examiner CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine g physician and as the burlal-transit or Attending Physician: The law requires that the death certificate be executed DISEASE CORONARY ARTERY Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ KIDNEY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 100 1 □Yes 2. No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 □Yes 2 □No ours after death.

neral Director: A
filled in by the fu investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

3001 S. HANOVER STREET, BALTIMORE, MD 2/225 LEE 31. Date filed (Month, Day, Year) 32. State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



Registrar

29c. License number

RES OOU

29d. Date signed (Month, Day, Year)

2009

AUGUST 25.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

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E	Physicia	ın	1. Decedent's Name (First, Middle, Last)	242					2. Date of Dear Month	a Day	Acog	3. Time of Doda 8.17 P	ath ·
	/Medic Examin	_	4a. Facility Name (If not institution, give street and numb	er) C		4b. City, T	Town, or Lo	ocation of Death		4c. C	ounty of Deat	n	
26	S. Marie Marie Milania		HAMOOT HOSPITAL	Carl	RV.	'AC	1 30 00 0	Dre			mitt Ac		
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. la.		If Under Months		f Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day)</li></ol>	, Year)	9. Birti Co.	nplace (State or Fo untry)	reign
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	or 28	Funeral Director	10e. Street and Number			10f. Zip	Code		1	l 0g. Citize	en of What Co	untry?	
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ē,	es 1 a of Hea		20a. Method of Disposition	20b. Pla	ace of Disperent	osition (Nam	ne of ther place)		Date	20c. Loc	ation - City or	Town, State	
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Baltimore,	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Litensie  K. Gregory Fink M01	148	2			of Facility al Home, P Hwy S., G1		, MD	21061		
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	To th withir To th comp	Me	29b. Signature and title of certifier			290	c. License			29d. Date	e signed (Mor	th, Day, Year)	
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	101		30. Name and address of person who completed cause	of death (Item	23a) (Type	Print)	ha	Rd. G	olen T	Bur	mie	MD 21	06
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TEM#10b, c, 10e, f, perfff, G895, 9/15/09, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month <u>Joan L. Saunders</u> 8:30 A /Medical Aug 23, 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 11 English Elm Ct Catonsville **Baltimore** 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 2 0 Months Days Hours Min. Director 057-28-4098 NY Aug 22, 1931 Usual Residence of Decedent with the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show th and Mental Hygiene.
?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examine in ust be notified at Baltimore Gity 1 ☐ Yes 2 No Director MD Baltimore Gity 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5444 Masefield Br. Funeral U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>\$</u> Specify: 3 Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John W. Lopata Eleanor Zuranski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Department of Health Important: If item 27 any injury or other theore. Jeannine Saunders, M.D. Daughter 11 English Elm Ct. Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ↓
■Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 27, 2009 Marriottsville, Maryland Crest Lawn Memorial Gardens 21. Signature Funeral Solice I 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soler the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (F disease or condition resulting in death) mediate Cause (Final SMAL **Physician** NON months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 15 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform 1 □Yes 1 ☐ Yes 2 □ No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,"

CATON AVE BALTIMORE

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Swenson		State of Maryland / Department of Pertificate of Registrar	of Death Reg. No. 2009 27/16
Physicia cal Exami	an/	1. Decedent's Name (First, Middle,Last) Paul Swenson	2. Date of Death  Month Day Year August 11, 2009  3. Time of Death 1520 hrs
		4a. Facility Name (if not institution, give street and number) 814 Mockingbird Lane #301	4b. City, Town, or Location of Death Towson  4c. County of Death Baltimore County
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 64 Y	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)Illinois
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	
th the Maryland 13a or 28a-f show any notified at .nce	Director	MD Baltimore Towson  10e. Street and Number  814 Mockingbird Lane #301	10f. Zip Code 10g. Citizen of What Country? 21286 USA
should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at since	uneral	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	/as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ld be filed within 72 hours after dental Hygiene. narked other than "natural", o	ed by F	during	Yes 2 X No specify: Specify: white ent's Usual Occupation (Give kind of work donenk most of working life. DO NOT use retired)  Specify: white  16b. Kind of Business/Industry  Dept of Human
uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical 1	Completed	12	Administrator Resources  18. Mother's Name (First, Middle, Maiden Sumame)
uld be filed within 7% Mental Hygiene. marked other than c event, the Medical	Be	17. Father's Name (First, Middle, Last)  Carl Robert Julius Swenson	Olive Leota Anderson
id 2 should lith and Me n 27 is ma aumatic ev	욘		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windshore Drive #203 Virginia Beach, VA 2345.
permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic		1 Burial 2 X Cremation 3 Removal from State crematory or	osition (Name of cemetery, other place)  Date 20c. Location - City or Town, State 20c. Location - City
permit. Page Department of Important: injury or oth		21 Sympton of Funeral Service Licensine / / / 22	Name and Address of FacilityPeaceful Alternatives Funeral & Creation State Anatomy Board 655 W. Baltimore Street Altimore, MD 212012325 York Rd. Timonium, Maryland 2
nysician Medical		23a. frant I. Enter the dispase, or complications that caused the death. Do not enter failure. List only one cause on each line. Diabetic ketoac	r the mode of dying, such as cardiac or respiratory arrest, shock, or heart idosis  Approximate Interva Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a consequence of):	
i ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
be executed sician and burial - transit	<u>a</u>	UNPENDED X AMENDED 23a,PII, per 16a,20a-	ME g896 10/21/09 TT c,22perfH,G895,9/1/09,WS
eath certificate attending phys	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy 23d. Date of delivery  Month Day Year  Other (Specify)
that the d	P.	Part II. Other significant conditions contributing to death but not resulting in the	A No. of No. of Brench to A Holonous
aw requires that as been signed 2 should be det	Completed by	Hypertensive cardiovascular diseas alcohol abuse	24a. Was an autopsy findings available performed?
ician: The la certificate h	Be Com	25. Was case referred to medical examiner?	1 Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one)
tal or Attending Physician: The law requires that it is after death  in Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	₽	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpati 27. Manner of Death 1 Natural 5 Pending Associated the second of the sec	
pital or Attend ours after death teral Director: filled in by the	] ≝	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospi within 24 hou To the Funet	Medical C	29a. Certifier Certifying Physician: To the best of my knowledge, death of	scurred at the time, date and place, and due to the cause(s) and manner as stated.  Igation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
F * F 3	Me	29b. Signature and title of certifier  Panal Southell, Mg	29d. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  August 12, 2009
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201
Regi	state		are

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Peter Scanlon, S		I- For State	State	e of Maryla		artment of			Menta	al Hyg	giene	J	21	10	0 2776
Dhuminin		Registrar 1. Decedent's Name (F	irst Middle I	aet)		illicate of	Deali			2	Date of De	Reg. No. ath	See S	3.	Time of Death
Physicia Medical Examir		Peter									Month August 2	Day 1, 200	Year 9		1123 hrs
		4a. Facility Name (if no	t institution, g	ive street and nu	imber)	1	4b. City, To					40	. County of D	eath	
		Calvert Memor	ial Hospita	al 			Prince	Frede					Calvert		
Funeral		5. Social Security Numl	1	Sex	7. Age (In yrs. I		If Unde	_	If Under Hours	1.6-				Count	lace (State or Foreign ry)
Director		074-22-659	7 1	X <sub>M 2</sub> F	{	80 <sub>Yrs</sub>		Bayo	1,100,10		June 2	20,	1929	Nev	y York
any		Usual Residence of De 10a, State 10b	cedent . County		10c. City.	, Town or Locati	ion							1(	Od. Inside City Limits
<b>*</b> .			nne Ar	undel		Loth								1	Yes 2 X No
nylan 3a-f si	턍	10e. Street and Numbe					10f. Zip	Code				10g. Cit	tizen of What	Country	1?
the Ma	Director	296 Rips D	rive					20	711				USA		
eath with the Maryland items 23a or 28a-f show ust be notified at once.	ia l	11. Marital Status	-37		edent Ever in U						cify Yes or N	lo-	14. Race - A White, e		n Indian, Black,
death or ite	Funeral	1 Never Married		1 Yes	2 X No		es, specify			rueno K	ican, etc.)				
s after ral",	à	3 Widowed		ed If Yes, Give Yes or Dates:		1 16a. Deceder	Yes 2				di deno	lich	Specify: V		
hour:		15. Decedent's Educa Elementary/Seconda			de completed)		ost of wor					100.	King or Busin	ess/11101	unk
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5-0036 led within 7 Hygiene. I other than		17. Father's Name (Fire	st, Middle, La		-	<u> </u>	<u> </u>			Name (F	irst, Middle	, Maider	n Surname)		
218 be fill mtal H rked	Be	Thomas S								Mar	у Мо1	1y M	leehan		
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name.				7							City or Town,	State, Z	ip Code)
MD and 2 sho salth and em 27 is		Norma C.		on/spous		Place of Dispos					nian, Date		20711 Location - Ci	ity or To	own, State
Baltimore, pernit. Pages I ai Department of He Important: If ite				3 Removal f		crematory or ot			,,					•	
ti. Pag rtmeni rtant: y or o		4 X Donation 5			1/2	122.1	Name and	Address (	of Eacility						
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Physician	0	23a. Part I. Enter the d			caused the death	n. Do not enter t	he mode o	f dying, s	such as ca	rdiac or r	espiratory a	rrest, sh	nock, or heart		Approximate Interval Between Onset and
/Medical		failure. List only of		a. Atheroscle	rotic Cardio	vascular Dis	ease								Death
xaminer		or condition resulting in		Due to (or as	a consequence o	of):									
	-e	Sequentially list condit if any, leading to imme		b. Due to (or as	a consequence o	of):								_	
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led nsit	Exa	events resulting in dea	ith) Last		a consequence of	of):									
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60, ate be ex hysician e burial	Med	IF FEMALE:		23c. If yes,	outcome of preg	gnancy	_				-	2	3d. Date of de	elivery	
P.O. Box 68760 that the death certificate i red by the attending phys detached for use as the br	Physician/Me	23b. Was decedent pre past 12 months?	gnant in the	1 Live			etal death	3	Ectopic	pregnan	су		Month	Da	y Year
Box e death co	/sici	1 Yes 2 No	9 Unkno	7	nant at time of de nown	eath 5 O	ther (Spe	cify)				1			
D. B t the d by the		Part II. Other significa	ant condition			resulting in the	underlying	cause gi	iven in Par	t I.	23e. Did	tobacc	o use contribu	ute to th	e cause of death?
ords, P.O. w requires that the same of the	d by										1 1	es 2	<b>✓</b> No 3	Probal	bly 4 Unknown
of Vital Records, g Physician: The law requir ther this certificate has been a neral director, page 2 should l	Completed										24a. Wa	as an topsy			psy findings available mpletion of cause of
eco ne law te has	ф	, —			-						pe	rformed's 2 🗸	? dea	ath? Yes	2 No
tal Rection: The certificate ector, page	ပိ	25. Was case referred	to medical					26.Place	of Death (	Check o					
Vita nysicia this ce direct	o Be	examiner?	No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 C	OA (	Other <sub>4</sub>	Nursing	Home 5	Resi	dence 6	Other:	
Of ing Pt	ī.T	27. Manner of Death	121-7	28a. Date (Mont	e of Injury h, Day,Year)	28b. Time of	Injury		y at Work?		28d. Describ	e how i	njury occurred	t	
tend tend death.	atio	1 Natural 5	Pending Investig	ation					es 2						
Division tal or Attendi rs after death. al Director: /	Certification:	3 Suicide 6	Could r	ot be	ce of Injury - At h	home, farm, stre	et, factory	, office bu	uilding, etc	i.   i		n (Street n, State)		or Rura	al Route Number, City
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director.	Ce	4 Homicide 29a. Certifier		(0,000)		dan dooth once	urrod at the	time de	to and pla	co and o	tue to the c	auco(c)	and manner a	e stater	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Chook only	etifying Phys edical Exami	sician: To the be ner:On the basis	of examination	age, death occu and/or investiga	ation, in m	opinion,	death occ	ce, and to	the time, da	ate and p	place, and due	e to the	cause(s)
To vitl	Mec	29b. Signature and title		and manner	stated.			. License					d. Date signed		
		fameto 6	Bouts	all m	<b>/</b> )			O.C.N	И.Ε.			Αι	ugust 22, 2	2009	
		30. Name and address	of person wh	no completed cau	use of death (Iter										
		Pamela E. So		Assistant	Medical Exa	aminer 1	11 Penn	Street	, Baltim	ore, M	D 21201				
	ate	31. Date filed (Month	Day, Year)		egistrar's Signa	ture 1	enter	9							
Regist	rar	AC	OI	<u> 2009   "Z</u>	ener	ju. juda	Media								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:13 A.M JOHN ANTHONY SERGI August 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X** M 2 □ F Days Hours Jan. 18, 1939 70 Director 220-36-7302 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🕅 No Maryland Baltimore Towson ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiens. Important; if Health and Mental Hygiens, Important; if Health and Mental Hygiens are Important; if Heart 2 is marked other than "natural", or items 23a, any injury or other traumatic event, the Me. I call Examiner must be Funeral 821 Fairway Drive 21286 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+)
2 vears Elementary/Seconday (0-12) Manager vears Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Benjamin Sergi Julia Mollie Tacchetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Sergi Fairway Drive Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 8-31-09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Green Mount Crematory <sup>22</sup> Name and Address of Facility Mitchell-Wiedefeld Funeral Home 6500 York Road Baltimore, Mary 21. Signature of Funeral Service Licensee 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ortset and Death Physician disease or condition Medical resulting in death) Due to (or as consequence of) Examiner advani LINCHOWS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALES 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown has been signed by the a 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate har funeral director, page 2 No Yes the Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one) 29b. Signature and title of

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

6701 nature

29c. License number

Amend 19a-b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** GLADYS SCHWARTZ 28, 7:15 PAULINE 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County

Birthplace (State or Foreign PRESBYTERIAN HOME OF MARYLAND Towson 8. Date of Birth (Month, Day, Yea April 24, If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) Days Min. 1 □ M 2 🙀 F Months Hours 87 Maryland Director 218**-**14**-**2758 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Maryland | Baltimore County Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3213 Mayfair Road **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edgar Schwartz Bessie Estelle Warner ပ္ 19a Informant's Name/Relationship (Type. Print) 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <del>Lilah</del> G. Schwartz 3212 Mayfair Road, Baltimore, Maryland 21207

pe of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 9/3/2009 4 ☐ Denation 5 ☐ Other (Specify) Woodlawn, Maryland 21. Signature of Fulforal Service Ucensee 23 Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC mound Martin D. 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Canter **Physician** ancrea /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 2 40 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director: A 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a ca 29a. Certifier 154. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 37016 August 28, 2007 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth M. Greene, M.D., 6701 North Charles St, Baltimore, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2 per MD 88/31/109 TI

Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Concentrate Name   Pick deliver, Last   Pick deliver, La				1- State of Maryland / Dep Registrar Ce	artment of Health and I <i>rtificate of Death</i>	, ,	iene <sub>eg. No.</sub> 2 / / / C	27771
Examinor    Second   Control of Director   Country   Cou		Dharini		1. Decedent's Name (First, Middle, Last)				3. Time of Death
Dundalk   Dund		_		John Thomas Sappington	Sr.			6:00A M
Social Security Numbers   Color Security Num					4b. City, Town, or Location of Death		4c. County of Dea	th
Part   Control								
Physician   Control of the control	r			1 <del>5</del> 7 M 2 D F		(Month, Day,		thplace (State or Foreign ountry)
Too. Sizes 100. Court of Services 100. Court		~		217-34-2803 /4		Nov. 20	,1934 Ma	ryland
Physician   Model Cal   Examinor   Physician   Physici		land ow			ocation			10d. Inside City Limits
Physician   Model Cal   Examinor   Physician   Physici		Mary -f sh	to	Maryland Raltimore	Dundalk			1 □Yes 2 ☑ No
Physician   Model Cal Examinor   Physician		r 28a	irec			10	ng. Citizen of What Co	ountry?
Physician   Model Cal   Examinor   Physician   Physici		h with		1901 Guy Way	21222		United St	ates
Physician   Model Cal   Examinor   Physician   Physici		death	ner		Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian,
Physician   Model Cal   Examinor   Physician   Physici	9	after or ite		1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ No		nican, etc.)		e, etc.
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Physician   Model Cal   Examinor   Physician   Physici	E	Page sent c nt: If ry or		129 Burial 2 Li Cremation 3 Li Hemoval from State	· · · · i	2/2009	Middle R	iver. MD
Physician   Model Cal   Examinor   Physician   Physici	a ≡	rmit. porta porta y inju		21. Sign ture of Funeral Service Licensee	2. Name and Address of Facility			
Physician Medical Examinor    Physician Medical Examinor   Physician Medical Examinor   Physician   Ph	Δ	<b>8 3 1 8</b>		Ne.C.	Duda-Ruck Funeral	Home of Dundalk.	MD 21222	Inc.
Physician   Modical Examinor   Modical Examinor   Modical Examinor   Modifical Examinor   Mod			7	23a. Part 1 Enter the disease, or complications that cause I the death. Do not en				Interval Between
Due to (or as a consequence of):    Suppose   Part   Common   Part   Control   Part   Pa	3	Physician			enhosis			Onset and Death
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Section   Color   Co	_	xecut and I-tran	хап	that initiated events c.				
FEMALE:   236. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year	9	be e sician buria		200 to (a) as a solidoquellito of				
FEMALE:   236. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year	587	ficate g phys s the	adic	d				
1 Space of District Part of District Par		+ 20 00		23b. Was decedent program 23c. If yes, outcome of pregnancy			23d. Date of de	livery
The state of the s	m	death e atte d for	icia	in the past 12 months? 1 □ Live birth 2 □ Fetal death 31				
The part of the pa	0	t the by the ache	hys					
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manny f Death 1		ss tha gned		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manny f Death 1	ğ	equire en si	ed .			1 □ Ye	s 2.27No 3P	robably 4 Unknown
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manny f Death 1	ပ္ပ	law re as be 2 sho	plet				24b. Were a	utopsy findings available
25. Was case referred to medical examiner?	_	The ate h	E O			perform	ned?   death?	
The statural	ita	ctor,		examiner?	26. Place of Dea		`	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222	<u></u>	hysi this c		1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	TIL 3 LL DOA   4 LL Nursing H	ome 5 Reside	nce 6 ☐ Other (Spe	ecify)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222	Ĕ	ing P	ö	1 ☐ Vatural 5 ☐ Pending (Month, Day, Year) Injury	Work?	28d. Describe ho	w injury occurred	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and dudress of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222	S 10	tend leath tor: / the f	cati	Could not be				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222		i Sign	rtif	4 ☐ Homicide determined 28e. Place of Injury - At nome, farm, sti building, etc. (Specify)	reet, factory, office	City or Town	reet and Number or H , State)	ural Houte Number,
29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222		spital ours ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	h occurred at the time, date and place	and due to the ca	ause(s) and manner a	s stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222	1	e Hos 24 h e Fur letely	dic	(Check only 2 ■ Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222		Vithir vithir comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mon	th, Day, Year)
Ali Siani, M.D. 6730 Holabird Ave. Baltimore, Maryland 21222					114419	3	7/25	107
31 Data filed (Month Day Vaar) 22 Benietra's Signature				30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	el		
State 31. Date filed ( <i>Montin</i> , <i>Day</i> , <i>Year</i> ) 32. Hegistrar's Signature  Registrar  AIIC 9 7 2000					Baltimore, Maryl	and 212	22	
				31. Date filed (Month, Day, Year)  ALIG 2.7 2009  August 2. Hegistrar's Signature	les l			

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Bruce Lee Satterfield 5:50pm Aug. 26 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Joseph Richie Hospice</u> Baltimore 9. Birthplace (State or Foreign Country) <u>Baltimore</u> Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) 1 □xM 2 □ F Months Days Hours 212-42-6227 66 Jan 3, 1943 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 DXes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2863 Lake Ave. 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 ☑No Specify Specify: Black 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unknown Laborer Crown Cork & Seal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Willie L. Satterfield</u> Ruth Plummor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2863 Lake Ave. Balto. MD 21218 JoAnn McCray-Johnson/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) GreenMountCrematoryAug28,2009Baltimore,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause or each line. Do not enter the mode of dying, such as cardiac or respiratory arrest,

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f shov

ral", or items 23a or 28a-f sho

or other traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medic once.

Baltimore, Maryland 21

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Records,

Vital ot

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or Attending Physician: The

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Director

Funeral

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Completed

Be 2 MD

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

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	disease or condition resulting in death)	Herntona		Montus
_	Sequentially list conditions.	Due to (olas a consequence of):  Curry was of the line		Years
Examiner	if ally, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): B and C  Due to (or as a consequence of):		Years-
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
ted by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.		se contribute to the cause of death?
Completed	Jementa Hyperten	8 W	24a. Was an autopsy performed? 1 □ Yes 2 🔼 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only one)	
	1 Yes 2 No	lospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing He	ome 5 🗆 Residence	Souther (Specify) TOS L ( 2
Certification: To	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street an City or Town, State	d Number or Rural Route Number,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 25, 2009 Year Physician 6:25 P Francisco Ramon Saenz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Montgomery 11404 Duryea Drive 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 88 Vrs September 2,1920 Mexico 133-26-0234 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Machal Experimental Property on the property of the pro 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Director Potomac Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11404 Duryea Drive 20854 Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 🙀 Married 1 ☑ Yes 2 □ No Specify: Mexican Specify: White If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Banking & Finance Elementary/Secondary (0-12) College (1-4or 5+) Economist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonor Hinojosa Julian Saenz ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Brooke Drive, Rockville, Maryland 20851 Christian P. Saenz/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition August 31, 2009 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01498 - du 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Heart Disease years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) P.O. □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 26, 2009 D0014116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue #700, Chevy Chase, Maryland 20815 Gerald Shugoll, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per, Phy. C895, 19/24/09 JHnort of Health and Montel Hygiene

Director    229 - 03 - 8178   1	1-)
Physician /Medical Examiner  4a. Facility, Name (If not institution, give street and number)  4b. City, Town, or Location of Death	ace (State or Foreign P. G. IN IA)  d. Inside City Limits  1 Yes 2 No
Funeral Director  4a. Facility Name (If not institution, give street and number)  4b. City Town, or Location of Death  4c. County of De	ace (State or Foreign  TY)  G (N)  d. Inside City Limits  1   Yes 2   No
Funeral Director  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  8. Date of Birth (Month, Day, Year)  Country  Usual Residence of Decedent	d. Inside City Limits  1 Yes 2 No
Director  229 - 09 - 8178 1 M 28 F 85 Yrs. Months Days Hours Min. (Month, Day, Year) Country Usual Residence of Decedent	d. Inside City Limits  1 Yes 2 No
Osual Residence of Decedent	d. Inside City Limits  1 □ Yes 2 No
The street and Number and State and Number and	1 □ Yes 2X No
10g. Citizen of What Country  10g. Citizen of What Country  10g. Citizen of What Country  10g. Citizen of What Country  10g. Citizen of What Country  10g. Citizen of What Country  11g. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American  15. Maried Forces?  16. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	A. C.
Total Status  10. 2ip Code  10	1-)
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	n Indian,
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21. Signifure of Funeral Service Licensee 22. Name and Address of Facility   towell funeral [	307
shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician disease or condition COLON CANCER WITH METASTASIS	Onset and Death
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autopsy prior to complete the second death?  □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	pletion of cause of
Autopsy: performed?   1   Yes   2   No	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home & Residence 6 Other (Specify)  27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at 28d. Describe how injury occurred	
27. Manner of Death  1	
The state of the s	Route Number,
Certain of the control of the contro	
The state of the s	ted. he cause(s)
29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month), Date si	ay, Year)
M.D. DS7722 AUGUST 26	2009
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	8
State Registrar  AUG 31 2009  A.D. 1838 GREENE TRUE ROAD #300 PILLES VILLE MP 2120  AUG 31 2009  State Registrar  AUG 31 2009  AUG 31 2009  Shown A. P. 1838 GREENE TRUE ROAD #300 PILLES VILLE MP 2120  AUG 31 2009  AUG 31 2009  AUG 31 2009	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** F. Tully Joseph 5:45pm <sup>™</sup> 8/27/ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1724 Langport Avenue Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/18/1959 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 50 Yrs. 5. Social Security Number 6. Sex **Funeral** Hours Days 213-78-2594 1**№** M 2□ F MD **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at Baltimore Dundalk Maryland 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1724 Langport Avenue 21222 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∰Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 "natural", or 1 □Yes 2XDNo Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Item 16 Elementary/Secondary (0-12) College (1-4or 5+) Food Service Cook Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles B. Tully, Sr. Mary F. Reckline ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karenlee Tully / Wife 1724 Langport Avenue, Dundalk MD 21222 Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition **\*E**Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 8/31/2009 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service LicenseeVictor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** MONTY 4800 disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the Innerial investor, page 2 should be detached for use as the burlar-transit completely illied in by the Innerial director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 255 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide determined 4 Homicide within 24 hours a 29a, Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. Baltimore, Manyland 21225 MO 300 | S.
32 Registrar's Signature VAN ECNO, MO Hanovar 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G894, 8/31/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 7:54 P M AUG 28, RUTH ELIZABETH THURMAN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 511 WEST PRATT ST. BALTIMORE APT 1607 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min 1 □ M 2 🗓 🗶 Director MONROE 438.82.5884 61 JULY 13, 1948 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 YYes 2 □ No Directo MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 511 WEST PRATT ST. APT. 1607 21201 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 (A)No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify þ Specify: WHITE 3 Widowed 4 X Vivorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 24 12 REGISTERED NURSE MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental 27 Is marked of traumatic ever ပ DeWITT HOGAN LENA BOYD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I SON PAUL THURMAN 511 WEST PRATT ST., APT 1607, BALTIMORE, MD 21201 item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 jo permit. Pages Department of Important: If it any Injury or o 1 KNBurial 2 Cremation 3 KNBemoval from State 4 Donation 5 ☐ Other (Specify) EBENEZER CEMETERY SEP 3, 2009 JONESBORO, LA uneral Service Lice se ef TAK FUNERAL HOME, P.A. CREGORY FINK | 426 CRAIN HWY.SW, GLEN BURNIE, MD 21061 M01148 . Enter the disease, o or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist may one cause on each line. Approximate Interval Between Onset and Death sho Immediate Cause (Final disease or ition **Physician** 9 mos Dere resulting in death) /Medical Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autops 1 ☐ Yes 2 Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \subseteq Nursing Home 1 🗌 Yes Certification: To 5 Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A 4 Homicide Hospital 29a, Certifier Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar University Of Md. 22 South Greene St. Balto. Md.21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month **Physician** Auguat 9, 11:00 PMM Helen M. Wilderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Heartland of Hyattsville Hyattsville 9. Birthplace (State or Foreign Country) Louisiana If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Dec 16, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 ☐ M 2 🛱 F 95 433-10-1318 1913 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Prince George's 1 ☐ Yes 2 No Director Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6500 Riggs Road 20783 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Yes 2∭ No f Yes, Give ′ear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 💢 No Specify: Specify: black þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) assistant manager housing Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heary Louise Hearn Denis McConduit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Forte-Mackay/niece 7511 Jaffrey Road Fort Washington, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) permit. 21. Signature Funeral Service State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Carles (Final disease or condition) Approximate Interval Between Onset and Death ARDIOP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of the cause of the cause of the cause of the cause of the cause of the cause Due to (or as a consequence of) Examine and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 🗹 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Matural Injury 1 Tyes 2 □ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral C completely filled i

> State Registrar

Medical

108 31. Date filed (Month, Day,

AUG 31 2000

29b. Signature and title of certifier

29a. Certifier

(Check only one)

132 5A

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

HARROVEK

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<sup>Day</sup> **Physician** 2009 10:05 P M Ronald William Walsh August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium Stella Maris If Under 24 Hrs. 8. Date of Birth 12-11-1943 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days Mar 91 and 1 M 2 □ F 65 Director 219-42-5727 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm McCloal Examinating at the motified at 1 XYes 2 No Baltimore Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 2527 Glencoe Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 X No Specify: Specify: à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lumber Industry Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Sandkuhler Andrew Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21234 2527 Glencoe Road Mrs. Roseanna Walsh - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entonburent Baltimore, Maryland 09-01-2009 Moreland Memorial Park 5305 Harford Road 21. Signatu e o Fungral Service 22. Name and Address of Facility Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that (aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause by each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPLE MYELOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2X No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  ${}_{4} \square$  Nursing Home  ${}_{5} \square$  Residence  ${}_{6}$   $\mathbf{X}$  Other (Specify)  $\mathbf{HOSPICE}$ Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical \* only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) X Nurse Practitioner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

AUG 3 1 2009

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12, 06:15A AUGUST 2009 LILLIAN JEANETTE ADAMS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTERTOWN NURSING & REHAB If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F 12/26/1928 DE 222-18-2909 80 Director Usual Residence of Decedent 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be rutified at 1 XYes 2 No Director CHESTERTOWN MD KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 415 MORGNEC RD. 21620 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: WHITE If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the M HEALTH CARE SWITCHBOARD OPERATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM ELWOOD STUART MARY O'DAY ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 ROLLING RD. CHESTERTOWN, MD 21620 permit. Pages 1 and 2 Department of Health Important; If item 27 any injury or other truonce. EVELYN GLENDENNING/POA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/09 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
130 SPEER RD. CHESTERTOWN, MD 21620 Kut Q 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause and line. Approximate Interval Between Oaset and Death Immediate Cause (Final disease or condition resulting in death) terios deretre ( years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a some guence of Examiner sician and burial-trans Due to (or as a consequence of): physician sthe burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown g 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sh autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? this certific al director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Certification: To Medical

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

within 2 To the I 2

MY S State Registrar

and manner stated. 29c. License number 29b. Signature and title of certifier

mo

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Das 17036/MI.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n ton Md 21420 - Susan K, Ros 3 mit Washing

1 L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

4 Homicide

29a. Certifier (Check only

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	•	rtment of F tificate of I		, ,	ene g. No.?	27780
	Physici	an	1. Decedent's Name (First, Middle, La Elizabeth Frahm	,	•			2. Date of Death Month	Day Yea	3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv			4b. City, Town, or	r Location of Death		13, 2009 4c. County of D	6:05 P M
1	LAGIIIII	ICI	2-D Northway	,		Greenbe.			Prince (	George's
	Funeral Director		340-20-7887	ex 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 26,	9. 1 1925 II	Birthplace (State or Foreign Country) Linois
	and ww		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	cation			_	10d. Inside City Limits
	Marylan -f show	tor	MD Prince G	Green	belt					1 ∑Yes 2 ☐ No
	or 28a	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	23a c	ral	2-D Northway			20770		U	SA	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Event her must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Black, W	merican Indian, hite, etc. Thite
5-0	72 hor	eted	15. Decedent's Ec	lucation 1	6a. Deceo	lent's Usual Occup	nation during most of work	king 1	6b. Kind of Busine	ss/Industry
121	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)			
d 2	filed within Hygiene. other than sent, the Me		17. Father's Name (First, Middle, Last)		Libra	rıan	18. Mother's Nam	ne (First, Middle, M		overnment
lan	2 should be filed h and Mental Hygi is marked other raumatic event,	To Be	Richard Xavier Wa					et Frahm	,	
ary	12 should th and Mer 7 is marke traumatic	-	19a. Informant's Name/Relationship (		19b. Mailin	g Address (Street		ral Route Number,	City or Town, Stat	e, Zip Code)
	DEC		Drake Richard All					, MD 207		
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State	e of Dispos etery, crem	sition (Name of natory or other plac	ce)		0c. Location - City	
Baltimore,	permit. Pag Department Important: I any Injury o		4 ☐ Donation 5 ☐ Other (Specif	r IIId.				3/15/09 W	<u> </u>	
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signal re of Funeral Service Licer	ente MO125	1 Be	verly L.	Heckrott		Clarksvil	le, MD 21029
	Physician		23a. Part 1. Enter the disease, or com shock, or heart fallere. List only Immediate Cause (Final disease or condition	plications that caused the death. If one cause on each line.  Dementia	Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 5 years
1	/Medical Examiner		resulting in death)	Due to (or as a consequen-	ce of):					
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequent	ce of):					
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oʻ	ifficate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequent	ce of):					
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	ath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	ath 3□	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
<u>~</u> .	that the dened by the detached		Part II. Other significant conditions of	ontributing to death but not resultin	g in the un	iderlying cause giv	en in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
ds,	uires tha n signed Id be det	d by	Low Pressure Hydr	•	<u> </u>			1 □ Ye	s 2 <b>∑</b> No 3□	Probably 4 Dunknown
000	law requir as been s 2 should	Completed	Hypertension					24a. Was an		autopsy findings available
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ital		Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	_4 \	es 2 🗆 140
of V	ys dir	၉	1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐ ER			4 LI Nursing H	ome 5 XResider	· · · · · · · · · · · · · · · · · · ·	Specify)
ou c	ding F	ion	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	b. Time of Injury	28c. Injur Worl	yat k? Yes 2 ⊟No	28d. Describe how	v injury occurred	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		, farm, stre		res Z 🗆 NO	28f. Location (Str. City or Town,	eet and Number of State)	Rural Route Number,
	ne Hospital n 24 hours a ne Funeral t pletely filled	Medical (		nysician: To the best of my knowle niner: On the basis of examination and manner stated.						
	To the I within 2 To the I comple(	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (M	
	€.6		)./	Ture te	TO		1757	>	8/14	109
_	<b>R</b> 5		30. Name and address of person who David S. Granite,	M.D. 115 Center	cway	Greenbe	lt, MD 20	770		
	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's Signature	1 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 1 - State Registrar #8, per fh, 8/18/09 tj Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** CRYSTAL C. ADKINS August 14, 2009 1555 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4501 Jacksonville Road
5. Social Security Number 6. Sex Somerset

9. Birthplace (State or Foreign Country) Sfield TUnder 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F Months Hours Min June 60 Director 1949 West Virginia 221-34-0017 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exat. it me must be matthed at 1 ☐ Yes 2 ☐ No Director Maryland Somerset Crisfield 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 4501 Jacksonville Road Funeral 21817 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ▼No Specify: Specify: White ð 3√⊒Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 Dollar Store Manager permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Bonds ပ Colleen Erwin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Hensley (Daughter) 531 W. Main St. - Apt. 202 - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory
22. Name and Address of Facility 8/15/2009 Salisbury, Maryland 21. Signatur Funeral S rvice BRADSHAW & SONS FUNERAL HOME Beth Bradshaw-Pruitt <u> 306 W. Main Street - Crisfield, Maryland</u> 21817 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): the attending physician P.O. Box 68760 Physiclan/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) detached 9 Unknown 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 □ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) f⊠Yes 2⊟No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

To the within 2 the

State Registrar (Check only one)

29b. Signature and title of certifier

Vijay Karumbunathan,

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 17 2009

M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D-48098

201 Hall Highway - Crisfield, Maryland 21817

29d. Date signed (Month, Day, Year)

August 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylan		artment of F		Mental Hy	2.0	ng	27	782
			Registrar  1. Decedent's Name (First, Middle,	( act)		Cei	lilicate of l	Dealli	2. Date of De	Reg. No. C	UU	3. Time of	of Death
	Physicia		Theresa Ann	Bue11					Month	Day 200	Year		a.m.
1	/Medio		4a. Facility Name (If not institution,		mber)		4b. City, Town, o	r Location of Dea		4c. County		3.21	er s in s
	Examini	e	St. Mary's Hospi		,		Leonard	town		St. Ma	arv's	:	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days			th		olace (State	or Foreign
	Director		215-70-7765	1 □ M 2 🔀 F	53	Yrs.	Widnins Days	Tiouis Will	06/04/			York	
	w .		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					0d. Inside (	City Limits
	/aryla	ō		1								1X□Ye	s 2□No
	the l	Director	Maryland St. Man  10e. Street and Number	ys	Leon	ardtow	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?	
	3a oi	a D	22755 Lawrence A	venue			20650			United S	State	S	
	death	Funeral	11. Marital Status		edent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (	Specify Yes or No		e - Ameri	can Indian,	
õ	after or ite mine		1 Never Married 2 Marrie	d 1 ☐Yes If Yes, G	2 📉 No	1	1 □Yes 2 XNo	Specify:	rto riicari, ctc.)	Specify	k, White,	etc.	
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show fical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or D	ates:						Wh	ite	
7	"nat	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of wo	orking	16b. Kind of ອີເ 	usiness/in	austry	
7	within iene.	ᄩ	Elementary/Secondary (0-12)	College (	1-4or 5+)		Service 1	<b>'</b>		Food Se	ervio	.e	
0	illed Hyg other ent, I	BeC	17. Father's Name (First, Middle, La	ast)		1		18. Mother's Na	ame (First, Middle	, Maiden Surnam	ne)		
land	Ald be Aenta rked ric ev	To B	William J. Buell	L				Phyllis	F. Marc	ella			
Mary	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than 'ratural', or items 23a or 28a-f show aumatic event, the restrict Examiner must be notified at		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zij	Code)	
Σ.	and 2 ealth n 27 i		Phyllis F. Buell	/Mother			Lawrence		, Leonar			0650	
9	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic es once.	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from	State 20b. F	lace of Dispo emetery, crer	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or To	own, State	
Saitimor	tmen tant:		4 ☐ Donation 5 ☐ Other (Spe	ecify)	Cha		Memorial		17/2009	Leonard	town	, MD	
g	permit Depar Impor any ir		21. Signature of Funeral Service Li	X Und	HO W	W	2. Name and Addre	D.	rinsfiel				
			Danielle Ward 23a. Part1. Enter the disease, or c		_		2955 Ho11	•			, MD	2065 Approxima	
			shock, or heart failure. List of	nly one cause on	each line.					arrest,		Interval B Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a consequ	1872 7	Trail U1/P	LVICE					
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	T +	ner	if any, leading to immediate	Due to	(or as a consequence	uence of):						VEZ	
	ecuter Ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c			ONALE					YET	<i>y</i> y
Ď,	cate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a consequ	uence of):							
2/00	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d									
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ž 20 20	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2   Feta	Ideath 3	Cotopic pregnance Other (specify)	у			onth	Day	Year
j.	t the c by the achec	hysi	9 Unknown	9 □ Unk	nown								
ν. Τ	ss tha gned	by P	Part II. Other significant condition	_		ulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to t	he cause of	f death?
ecords,	equire sen si ould b	ted		21EN81	en/	<del> </del>			1 🗆	Yes 2 100	3 ☐ Pro	bably 4□	] Unknown
ပ္	law r nas be 2 sh	ple							24a. Was	an 24b.	Were auto	opsy finding	s available cause of
<u> </u>	: The cate h	Completed							perfe 1 ☐ Yes	ormed?	death? 1 □ Yes	•	
VII	ician certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:		/	Oth	or:	eath (Check only				
5	Phys r this ral dir	<u>1</u>	1 ☐ Yes 2 ☐ Mo 27. Manner of Death	28a. Date	Inpatient 2 🔽	ER/Outpatier 28b. Time of		4 🗆 Nursing	Home 5 ☐ Res	idence 6 Oth		fy)	
	ding th. After	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mor	oth, Day, Year)	Injury	Wor	k? Yes 2 □ No	200. Describe	now injury occur	cu		
VISION	Atten r deal sctor; by the	fica	3 Suicide 6 Could no	ot be 28e. Place	of Injury - At ho	ome, farm, str	eet, factory, office		28f. Location	Street and Numb	er or Rur	al Route Nu	ımber,
É	al or	Certification:	4 ☐ Homicide determin	build	ling, etc. (Specif	у)			City or To	wn, State)			
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical (		xaminer: On the I			h occurred at the ti vestigation, in my						e(s)
	Vithin To the Somple	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signe	d (Month,	Day, Year)	
	3		) /m			MD	D	16096		8-14	1-00	7	
T	10		30. Name and address of person w	ho completed cau	se of death (Item	23a) (Type,	ST MAA	71 MOS	PITAZ	LEON !	かりて	ONN	MD
	Sta		31. Date filed (Month, Day, Year)	2009	Registrar's Signa		west.	/ -	•				
	Registr	ar	1100 100	~	/	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 16, 2009 8:12 a August Blass Audrey Ann 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Hours Months Days 1 □ M 2 🛣 F 06/18/1953 New York 096-44-0528 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland | St. Mary's Lexington Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20653 46608 Yorktown Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Sales Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy S. Curtiss Owen Wright Gilmore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 668, Lexington Park, MD 20653 Evrand R. Blass/Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/22/2009 Port Byron, NY Mount Pleasant Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22955 Hollywood Rd., Leonardtown, MD 20650 Kyle S. Simons M01206 Approximate Interval Between Onset and Dean Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a d Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 \$\ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

Physician

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show Exal, increquet be notified at

Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23.
ury or other traumatic event, it as feation fers in a man

Baltimore, Maryland 21215-0036

the

Director

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Completed

Be

/Medical

10a. State

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital within 24 hours a To the Funeral Completely filled

P.O. Box 68760

Division of Vital Records,

Exam Physician/Medical 2 Completed Be Certification: To Medical

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 🗑 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only опе) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title #f certifier

24035 Three Notch Road, Hollywood, MD

20636

State Registrar

30. Name and address of person who complete

AUG

31. Date filed (Month, Day,

Jarboe,

18

M.D

DHMH 17 Rev 1/2001

ause of death (Item 3a) (Type

09-06376 Dawn Buckler Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 27784

WII BUCKIEI		- For State	State	Or Ivial ylaria	Certific	ate of	Death			Re	g, No.	ZU	UJ	6110
Physicia	_	egistrar 1. Decedent's Name								. Date of Death Month	Day Ye	ear	3. Time (	
edical Examir	_	Dawn	Marie	Buckle		Lat	City Town	, or Location		August 14,	4c. County	of Death		
	1	4a. Facility Name (i Route 238	f not institution, giv	e street and numbe	r)	41	Chaptico		J. 2004.		St. Mar	y's		
Europol		5. Social Security N	lumber 6. Se	ex 7. A	ge (In yrs, last bir	thday)	If Under 1	Year If Und	er 24Hrs.	8. Date of Birt	h (MM/DD/YYY	Y) 9. Bir Forei	rthplace (S	State or
Funeral Director		212-96-		M 2X F	45	Yrs.	Months I	Days Hours	Min.	07/27/	1964			ton.D.C
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any		10a. State	10b. County		10c. City, Towr								1	res 2 x No
Maryland <b>28a-f show any</b> <u>d at once.</u>	Ö	laryland	St. Ma	ry's	Mecha	nics		10		11	Og. Citizen of V	What Cou		
Maryl - 28a-1	Director	10e. Street and Nu					10f. Zip Cod			( )				1
death with the Maryland or items 23a or 28a-f sho			Asher Rd	12. Was Decede	nt Ever in I.I.S	13 Was	2065	f Hispanic Ori	igin? ( Spe	cify Yes or No			rican India	an, Black,
ath wi	Funeral	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ed 2 X Marrie	Armed Force	s?	If Ye	es, specify Co	uban, Mexical	n, Puerto F	Rican, etc.)	Wh	ite, etc.		
215-0036 be filed within 72 hours after death with the Maryland mal Hygeine. ** Red other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.		3 Widowed	4 Divorce	1 Yes d If Yes, Give Year	2 X No			No specify			Specify	1111	ite_	
ours af	d by	15. Decedent's E	ducation (Specify o	only highest grade c		. Decedent	st of working	upation (Give	kind of we Luse retire	ork done ed)	16b. Kind of	Business	s/Industry	
6 an "n	Completed	Elementary/Sec	ondary (0-12)	College (1-4 o	or 5+)			Medici			Heal	l+h (	Care	
withir grene.	E	12 17. Father's Name	/First Middle Las	1		Cert.	rried				Maiden Surnar		oare	
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212 ould be mark	2	19a. Informant's N									nber, City or T			de)
e, MD 21215-0036  I and 2 should be filed within 72 hours after Health and Mental Hygene, item 27 is marked other than "natural", rtraumatic event, the Medical Examiner.				Ler, Sr./1			9 Dann		ne,	CHaptic Date	O MD	2062 on - City (	or Town, S	State
re, s l and f Heal If iten	ı	20a. Method of Dis		Removal from	crem	atory or oth	ner place)		0 00		i			
Page Page nent c		4 Donation 5	Other Specif	fy:	Sacre			metery						yland
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other trau		21. Signature of F	uneral Service Vice	ensee MUI	0817	22. N	Brins	ield-l	Chol	s Funer	ral Hom Hall,	e, E	P.A. 20622	
Physician	H	23a, Part I Enter	the disease, or con	nplications that caus	sed the death. Do	not enter t	he mode of c	ying, such as	cardiac o	respiratory ar	rest, shock, or	heart	Appr	oximate Interval
Madical		failure. List o	nly one cause on	<sub>a.</sub> Multiple Injuri										Death
caminer		or condition result	1	Due to (or as a co										
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876 rtificate ing phy as the		23b. Was deceder past 12 month		1 Live birt	h	2 F	etai death		pic pregna	ancy	Mont	h	Day	Year
Box 687 he death certific the attending p	Physician/	1	No 9 🗸 Unkno		nt at time of death	5 O	ther (Specif	v)						
the de	P <sub>y</sub>			s contributing to d		Iting in the	underlying c	ause given in	Part I.		tobacco use c			
ires that the signed by I be detached	<u>\$</u>									1 Y				4 Unknown
ords, v require s been si	Completed by										opsy	prior	to comple	findings available tion of cause of
e law e has ge 2 sh	直										formed?	death 1		2 No
tal Rection: The certificate ector, page	ပ္ပိ	25. Was case ref	ferred to medical				26	Place of Dea		only one)				
of Vital Recling Physician: The I	o Be	examiner? 1 ✓ Yes	2 No	Hospital: 1 In		R/Outpatier			_	ng Home 5	Residence		ther: Scen	e
I Of ing Pt After uneral	Ë	27. Manner of De		28a. Date of (Month, I Aug 14, 2	f Injury 28 Day Year) 0009 1	3b. Time of 540 hrs	Injury 28	c. Injury at W			o fixed obje		ision	
Sion Attend r death. ector: by the J	jä ä	2 🗸 Accident	5 Pendin Investig	y ention	of Injury - At home	e farm str	eet factory.			28f. Location	(Street and N	lumber o	r Rural Ro	ute Number, City
Division of Vital Records, spital or Attending Physician: The law requir outs after death.  For A Director: Affer this certificate has been si filled in by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director, page 2 should by the fineral director.	Certification:	3 Suicide	6 Could r	not be	Major Road /					or Town Route 238,	, State) Chaptico, Mi	D		
Hospita 24 hours Funeral				T. 4b. b 4	of my knowladge	doath occ	urred at the t	ime, date and	l place, an	d due to the ca	ause(s) and ma	anner as	stated.	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funanta Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one) 2	✓ Medical Exami	sician: To the best iner:On the basis of and manner sta	examination and	or investig	ation, in my	opinion, death	occurred	at the time, da	ite and place, a	and ude	to the cau	
T <sub>o</sub> V <sub>i</sub>	Š	29b. Signature a	nd title of certifier	and marries of			29c.	License num	ber		1		(Month, D	ay,Year)
C.		th	Ch Bin	nell di	110			O.C.M.E.			August	. 10, 20		
0				no completed cause			Donn Ct-	eet, Baltim	ore Mr	21201				
A 10		l .	Irassell, MD	Assistant Med			renn Str	oci, Dailiff	IOI e, IVIL					
	State	31. Date filed (M	AUG 20	2009 32. R	gistrar's Signature	A. A.	rondo	7						

			Please	Type or P							gible.		
	1	For State Registrar		State of	Marylan		rtment of F tificate of I	lealth and M <i>Death</i>		giene Reg. No. 2	009	27	785
Dhysisian		Decedent's Name	e (First, Middle, L	ast)					2. Date of Dea	ath	Year	3. Time o	
Physician /Medica	1 L	Eugene Daniel Bittle					Month 08			12 2009 9:00 P M			
Examine	1	4a. Facility Name (If not institution, give street and number)  1210 Mercer P1.					4b. City, Town, or Location of Death  Frederick			4c. County of Death Frederick			
Funeral Director	- 1	5. Social Security N 219-36-2		Sex 1 <b>X</b> M 2 □ F	Age (In yrs. I	last birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3 / 2 5 /	1939	9. Birth	nplace (State Intry)	or Foreign
and and	- 1-	Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	cation					10d. Inside C	City Limits
Maryl Fired 2		MD	Fred	erick			ederick					<b>ty</b> Yes	s 2□No
h with the Mar. 23a or 28a-f sh et be notified	al Direc	10e. Street and Number 1210 Mercer P1				10f. Zip Code 21701			10g. Citizen of What Country?				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evaninar must be rediffied at once.  To Be Completed by Europea Director	2	11. Marital Status 1 □ Never Marri 3 □ Widowed	ied 2 X Married 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? □N1957	/ -	Was Decedent of H f Yes, specify Cuba I □Yes 2 XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. R B	lack, White	ican Indian, , etc. hite	
ed within 72 hou ygiene. er than "nature t, the Medical E	India	Elementary/Secon	15. Decedent's E cify only highest g	Education rade completed) College (1-4	or 5+)	(Give	dent's Usual Occup kind of work done o OO NOT use retired	during most of work	ing		ultr	у	
Hygier then the nt, the		12	/First Middle Las	**		OWI	ner	18 Mother's Name	e (First Middle	proce		.g	
nould be fill marked ott natic even	Roy D. Bittle Hazel Blickenstall												
and 2 st fealth and m 27 Is n her traun		Nancy E	Bittle		Jan	1210	Merce	r Pl, Fr	ederic	k, ME	217	01	
Pages 1 ment of H ant: If ite ury or ot		20a. Method di Disp 1 □ Buria 2 <b>3</b> 4 □ D <b>o</b> nation		Removal from Sta	, C	emetery, cren	sition (Name of natory or other plac urg Cren	matory8/	14/200	20c. Location	•		ſD
permit. Depart Import any Inj once.		21. Signature of Fu	uneral Service Lic	Co sc		22	Name and Addre Donald I PO Box I	B. Thomp 18, Midd	son Fu lletown	neral	Hom 2176	e 9	
Physician		shock, or hea Immediate Cause (	art failure. List onl (Final	mplications that cau y one cause on eac	h line.				or respiratory ar	rest,		Approxima Interval Be Onset and	etween Death
/Medical Examiner		disease or condition resulting in death)  a.     Due to (or as a consequence of):											
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per icia	LY2	Tis any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.   Due to (or as a consequence of):  Due to (or as a consequence of):  d.											
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that the death certificate be ed by the attending physici detached for use as the bu	Iyalcıaı	in the past 12 months? 1 Live birth 2 Fetal death 3					☐ Ectopic pregnancy ☐ Other (specify)			Month Day Year			
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ctan: sertifica sctor, p										2 □No			
this ce		1  Yes 2	•			ER/Outpatier		4 Li Nursing Ho	ome 5 Resid		. ,	cify)	
th.: After a funeral figor.		<ol> <li>Manner of Death</li> <li>Matural</li> <li>Matural</li> <li>Accident</li> </ol>	h 5		Day, Year)	28b. Time of Injury	Worl	ryat k? Yes 2 □ No	28d. Describe h	noo non ilgary occurred			
Hospital or Attending Physician: 44 hours agter death. Funeral Director: After this certification by the funeral director, lical Certification: To Be C		3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	De 290 Place of Injury. At home form street featon, efficient			eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
In the hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and death of the funeral directory.		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											(s)
To the comple		29b. Signature and	title of certifier	2	e m	וו	29c. Licens			29d. Date sign	ned (Month	n, Day, Year)	00
641		10. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Compared to the person who completed cause of death (Item 23a) (Type, Print)  Compared to the person who completed cause of death (Item 23a) (Type, Print)  Compared to the person who completed cause of death (Item 23a) (Type, Print)  Compared to the person who completed cause of death (Item 23a) (Type, Print)									701		
State Registrar		31. Date filed (Moni	th, Day, Year)	32. Reg	jistrar's Signat		es.			7 6 -1	- /		-/
	_			- Journal	10	250.000							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ ] [ ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Victoria Balko 2009 9:25 AM August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Worcester Berlin Nursing Home Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 2/25/1914 5. Social Security Number Birthplace (State or Foreign Country) Months Days Hours 1 M 2 XF 122-40-4692 95 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 □Yes 2 TXNo Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13 Rockside Road 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emilia Binau William Balandi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita McLaughlin / daughter 13 Rockside Road, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 8/18/2009 John's Cemetery Queens, NY 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 WIlliam St., Berliň, 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

**Physician** /Medical **Examiner** 

Physician

Examiner

**Funeral** 

Director

72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be muffled at once.

Baltimore, Maryland 21215-0036

Balko, Victori

/Medical

Director

Funeral

<u>}</u>

Be Completed

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MD

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

leral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital o within 24 hours af To the Funeral D

Division of Vital Records, P.O. Box 68760,

	disease or condition resulting in death)	a. Werrovascular acculent									
	resulting in death)	Due to (or as a consequence of):									
amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of).									
	resulting in death) Last	Due to (or as a consequence of): d.									
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year								
d by Pi	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Onknown								
Complete			24a. Was an autopsy performed?  1 Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?								
Be (	25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
၉	1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify)									
	27. Manns of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred								
Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)								
edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.										
Ž	29b. Signature and title of certifier	hage CRM 29c. License number R135/31	29d Date signed (Month, Day, Year)								

State Registrar

DH 3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage , 9715 Healthway Dr., Berlin, MD 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25 per phys. G895 9/28/09 dk
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** ROJE 2009 OLANGHARD AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KEN To Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth HESTER RIVER 8. Date of Birth (Month, Day Ye 9. Birthplace (State or Foreign Year) 1918 **Funeral** Months Days Hours 1 □ M 2 🖵 F VIRGINIA 90 578-28-4377 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 👿 No Director ROCK HALL MARYLAND KENT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21661 6928 ROCK HALL ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2□No Specify: \$ Specify: WHITE 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE 12 REGISTERED NURSE of Health and Mental Hygin item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MOLLIE JACOBS WALTER LEE GARDNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 844 MAGNOLIA AVE #1 PASADENA, CALIF. 91106 19a. Informant's Name/Relationship (Type. Print) MARIE SUZETTE BLANCHARD/ DAU. other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If ite any injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD CHESAPEAKE CREMATION CNR 8/17 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN, NEWNAM FH CHESTERTOWN, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician Irvin BREGMAN 11:40 A M 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Hospice Casey House Rockville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 X M 2 □ F Yrs **Director** 95 116-03-3958 July 8. 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Silver Spring Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 United States 8201 - 16th Street #825 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Vear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No WW II Specify: white à 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname)
Beckie Blecker Be ( 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once. Jacob Bregman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Yaakov Borenstein, Trustee 9505 Linden Ave., Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/14/09 Judean Memorial Gardens Olney, MD 21. Signature of Funeral S Licensee 01008 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Clostridium difficile Colitis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Acute Renal Insufficiency Due to (or as a consequence of) Physician/Medical Atrial Fibrillation/Flutter IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2**X** No 1 Tes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records,

Certification: To

Medical

State

29b. Signature and title of certifier J. Kouerchou

5 Pending investigation

6 ☐ Could not be

determined

29c. License number D 63748

1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) August 13, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD

31. Date filed (Month, Day, Year)

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

AUG 17

32 Registrar's Signature back

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** 2:00pm Marjorie 08 2009 Biggs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1503 Berkley Ct. Lot L. Lothian 7. Age (In yrs. last birthday) 75 Yrs. Birthplace (State or Foreign Country)

A 8. Date of Birth 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** Min. Hours 1 □ M XX F Months Days 578-42-7818 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10h County 10c City Town or Location 10a. State "natural", or items 23a or 28a-f show diest Examiner must be notified at 1 ☐ Yes 🛠 😾 No Director MD Anne Arundel Lothian 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with USA 20711 1503 Berkley Ct. Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 21K No Specify: If Yes, Give Year or Dates: Completed by 3 X Widowed 4 Divorced 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladies Hall ೭ Neil R. Reese 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau 3810 Weywood Pl. Bowie, MD 20715 Roger Johnson Sr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 8/14/2009 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funera Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence o): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of lifier 5828 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Hoeck, M.D. 4175 N.Hanson Ct. Bowie, MD 20716

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#30.PerPhys.PGC8-21-09 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month, 000 an **Physician** OWARN ROWN 1)8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin Hospice Harwood If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 GA 8. Date of Birth (Month, Day, Feb. 22, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Min. 1 M 2□ F Months Days Hours 1950 59 Feb. Director 230-64-4318 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ral", or items 23a or 28a-f shov Evaning rough be notified at 1 ☐ Yes 2x No Director MD Temple Hills Prince Georges the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 USA 3103 Good Hope Ave. Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 TXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Hospital College (1-4or 5+) Washington Adventist Maintenance Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steve Brown Mary Campbell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9112 Midland Turn Upper Marlboro, Md. 20772 Stephen Dennis Brown-Brother 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 8-20-2009 Landover, Md. ☑ Other (Specify) 4 □ Donation of Funeral Service 21. Signatus Marshall's Funeral Home of Maryland Suitland Rd. Suitland, Md. 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/10No 1 □ Yes 1 ☐ Yes 2 No neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Maryner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: dust 1 Natural 2 □ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital ( 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and mannes stated. To the Within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier w Name and address of person Michael State

Registrar

AUG 182009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** August 21 2009 7:50  $A^{M}$ Bilbrough /Medical Mary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Faston
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 25, 1924 Talbot 29981 Rabbüt Hill Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 85 Director 218-16-8414 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or items 23a or 28a-f show dical Examinations be notified at 1 XYes 2 No Directo Maryland Caroline Ridgely 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America Funeral 21660 410 Central Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: Caucasian þ 3 X Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker **Home** 11 HS grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Blackston srFrederick Victor Kirsch. Margaret L. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau
once. Daughter PO Box 221, Cordova, Maryland Mary Ann Swann 21625 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery Greensboro, Maryland 21. Signature of Funeral Service Licent Moore Funeral Home, P.A. lou 12 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner MC- JAI YNY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a consequence of The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) has been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 **2 N**o 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1" Natural 5 ☐ Pending 1 □Yes 2 □No investigation I Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral Di

completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 316 Midrana Idemond me

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

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			Registrar	( ant)			erunca	ile OI L		2. Date of D	Reg. No.	2009	3. Time of	Posts -
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2	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. I Hygiene. I have smarked other than "natural" or items 23a or 28a-f show umatic event, the Modical Exercity.	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. M	ailing Addre	ss (Street a		Rural Route Num	ber, City or	Town, State, Zi	p Code)	
Ž	od 2 ulth a 27 is r trau		Constance M. Barker	/Daughter-	In–I au	371	O Waw	onaic	ea Trai	1, Fort	Mayno	TN /	6800	
ນົ	tem f Hea		20a. Method of Disposition		2	20b. Place of Di	sposition (N	ame of	54 1141	Date		cation - City or T		
2	ages ent of tt; If i		1 Burial 2 Cremation		State	20b. Place of Di cemetery, o Cherry Methodi	rematory or Hill	other place	Aug	ust 26,		11	:11 M	D
Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Moderal Examination at any injury or other traumatic event, the Moderal Examination of the College and once.		4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Funeral Service			Methodi	st Cei	<u>neter</u>	y 200	9	1 0	herry H	111, M	υ <u> </u>
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			30. Name and address of person	who completed car	ise of death	ı (Item 23a) (Tvi	oe, Print) N		0 10:					
			NIS Raircoakse m	·D	25	Mainsto	Suite	200,	Kent	istown,	MD.	2113	6.	
	Sta	te	31. Date filed (Month, Day, Year)	0 1 0000	Registar's	Signature	1.	· 0						
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**ORIGINAL** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 8/13/2009 9:20 A <u>Agnes Catherine Cascio</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Worcester 9. Birthplace (State or Foreign Country) Assateague State Park If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours 1 □ M 2√ F 8/30/1928 80 Yrs MD 212-26-0395 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2√☐ No Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 217 North Rolling Rd 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes & ☐ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Baltimore Co. Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clement Schaeffer Adalyn Lois Guthrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Cascio son <u>343 Walnut Hill Dr., Berlin MD 21811</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 8/14/2009 | Frankford DE 21. Signature of Furnal Service Licensee 22. Name and Address of Facility The Burbage Funeral Home <u>108 William St Berlin, MD 2181:</u> 23a. art1. Enter the disease or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or sach line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to for as a consequence of, Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2.Z No 1 Yes 2 🗆 No 1 TYes

**Physician** /Medical Examiner

attending physician and for use as the burial-trar

signed by the a

cate has page 2 s certificate

this : After thi

within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

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Completed

Be

Certification: To

Medical

Box 68760,

P.0.

Division of Vital Records,

Physician: The law requires that the death certificate be

or Attending

Hospital

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any Injury or other traur

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

28a-f show

Director

Funeral

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Completed

Be

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MD

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene.
27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, it e.M. died Exturity or unst be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Examin Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

WOKTH

25. Was case referred to medical examiner? 1 ∐Yes 2 No

29b. Signature and title of certifier

THY

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) CANIPED 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury at Work? 1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29a. Certifier (Check only

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DN 10

Registrar

31. Date filed (Month, Bay, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8/7/2009 1:10pm<sup>M</sup> Elva Mary Craver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Knollwood Manor Millersville 6. Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 90 Yrs. 1 ☐ M 2 K F 220-03-0559 4/25/1919 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show be notified at 1 □Yes 2√ No Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number "natural", or items 23a 21113 USA 519 Stoney Hill Ct. p\_rmit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examiner must Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 3 € No Specify: Specify: White <u></u> 3℃Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. Craver Agnes E. Gayhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pearl Hahn 1100 German School Rd. Richmond, VA 23225 Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Louden Park Cemetery 8/19/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service License Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h. art failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): BOWET Examiner SCHEMIC Sequentially list conditions, it any, bearing to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 BBSTRUCTIVE PULMONARY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ → Ho 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature as

State

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D31136

Gistar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / Depa	artment of Health a ctificate of Death	nd Mental H	/giene Reg. No. 2	9 27799
			1. Decedent's Name (First, Middle, Las	t)		2. Date of D		3. Time of Death
н	Physici		Maurice Ricardo	Cawthorne		August	11th, 2009	6:48 P M
and a	/Medio		4a. Facility Name (If not institution, give		4b. City, Town, or Location of	Death	4c. County of De	ath
	LXaiiii		3506 Rippling Way		Laurel		Prince G	eorge's
	Funeral		Social Security Number 6. S		If Under 1 Year If Under 24	Hrs. 8. Date of B	irth 9. B	irthplace (State or Foreign
	Director		235-34-9982 Usual Residence of Decedent	X M 2□ F 79 Yrs.	Months Days Hours	Aug. 1	rith (3a), (7ear) 9. B 8, 1929 V	irginia
	ylanc ylanc		10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	Mar a-f sk	호	Marvland Prince	George's Laurel				1√Yes 2□No
	r 28	ire	10e. Street and Number		10f. Zip Code		10g. Citizen of What (	Country?
	h wit	a	3506 Rippling Way	у	20724		U.S.A	
	deat	<b>Funeral Director</b>	11. Marital Status		Vas Decedent of Hispanic Origi f Yes, specify Cuban, Mexican,	n? (Specify Yes or N	o- 14. Race - An	nerican Indian,
9	or ite	II.	1 ☐ Never Married 2 ☐ Married	1 X 7 Yes 2 □ No	Yes 2 No Specify:	Fuerto Ricari, etc.)		ilte, etc. Black
03	ral",	g	3 X Widowed 4 □ Divorced	Year or Dates: 1952	Tes 2M No Specify.		Specify:	, Luck
21215-0036	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Exprignat roust be notified at	Completed by	15. Decedent's Edi (Specify only highest grad	de completed) (Give	lent's Usual Occupation kind of work done during most o	of working	16b. Kind of Busines	s/Industry
21	ithin ne. han "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)	3	ADVA	
2	ed w lygie her tl		12th	Milit			ARMY	
ıno	be fil ntal F id otl	æ	17. Father's Name (First, Middle, Last)			s Name (First, Middi ;ia Mae Ca	e, Maiden Surname)	
χ	ould Mer Marke	ဥ	A.W. Cawthorne					
, Maryland	and 2 shealth and 2 shealth and 27 is mertraum		19a. Informant's Name/Relationship (7 Marcella Cawthorne	ype. <i>Print</i> ) -Martin/daught. 3506	g Address (Street and Number Rippling Way L			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macical Evanding must be notified at once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State    20b. Place of Disposementary, cremoval from State   Restlawn M.	sition (Name of natory or other place) Iemorial Gdns A	Date .ug.17,200	20c. Location - City of Bluewell,	or Town, State West Virginia
äĦ	mit. Dartin Dorta Vinju		21. Sign type of Funeral Service Licens	see (/) 22	. Name and Address of Facility	Marshalls	Funeral Ho	ome, Inc.
m	Depar Depar Impor any ir		Derek &	43	08 Suitland Ro	ad Suitla	nd, Marylar	id 20746
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not entrope cause on each line.  a. Metastatic Pancres  Due to (or as a consequence of):		ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death 4 months
В	Lammer	-	Sequentially list conditions,	b. Due to (or as a consequence of):				
	ted 1sit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or).				
,00	cate be executed ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	C				
8760,	cate b	dical		d				
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Year
ds, P.	ires that signed by	by	Part II. Other significant conditions of	ontributing to death but not resulting in the ur	nderlying cause given in Part I.		tobacco use contribute	to the cause of death?  Probably 4 Unknown
Records,	e law require has been sig e 2 should b	Completed				24a. Wa	s an 24b. Were	autopsy findings available to completion of cause of
H F		S				per 1 □ Yes	formed? death 2 X No 1 Y	
/ita	i <b>lcian</b> ; Th certificate ector, pag	Be	25. Was case referred to medical examiner?			of Death (Check only	one)	
of Vital	Physician; r this certific ral director, I	ပ္	1 les 2 22 140	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		sing Home 5 🛭 Re	sidence 6 Other (S	pecify)
	ling After une	tion:	27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		e how injury occurred	
Division	i gift o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)		28f. Location	(Street and Number or own, State)	Rural Route Number,
	Hos Fun Fely	Medical C		yslcian: To the best of my knowledge, death iner: On the basis of examination and/or inv and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	000	29c. License number		29d. Date signed (Mo	onth, Day, Year)

State Registrar 1400 Forest Glen Road (Suite #435) Silver Spring, MD 20910

D33224

8-13-2009

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ram S. Trehan, M.D.

31. Date filed (Month, Day, Yea AUG 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per phys G895 9/1/09 dk.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 13:53 SO 13 2009 M. Nobage Minnie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, bwn, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** 1 M 2 F 70 8128138 221-50-5462 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show must be notified at 1 Yes 2 No Kent Director DE Frederica 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number or items 23a or 9946 Street 1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. • Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ortant: If item 27 is marked other than "natural", or itei injury or other traumatic event, the Medical Examiner 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nutrition School 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Sm 27 is marked ott Arlis Bryant enimus. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederica 54. De Health a A. C ubbase - husband Front 107 James Pages 1 ar nent of Hea int: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State Dover, DE 8/19/09 Hills Mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 615,1816dtord St Illu ausilus TORBERT FUWERALCHANEC Dover DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Renal Cell Caranoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter IJ dentying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Tectopic pregnancy Month Dav Year in the past 12 months?

1 Yes 2 XNo
9 Unknown Pregnant at time of death 5 Other (specify) detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ director, page 2 should be 1 T Yes 2 No 3 Probably 4√Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗌 No certificate 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be examiner?
1 Yes 2 No Other: 4 \sum Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No s after death 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 13/2009 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 17

DHMH 17 Rev 1/2001

Registrar

			1 _ State	tate of Maryland /		rtment of F <i>tificate of I</i>			0000	07707
			Registrar  1. Decedent's Name (First, Middle, Last)			incate of i	Jean	2. Date of Death	. No. /	3. Time of Death
	Physici /Medic		Thaddeus Allen	Ca1	limer		Į.	Month August 2	Day Year 2009	10:43 P <sup>M</sup>
1	Examin		4a. Facility Name (If not institution, give street			•	Location of Death	_	4c. County of Death	
~			16602 Buck Lantz Ro	7. Age (In yrs. last I	hirthday)	Sabillas If Under 1 Year	sville   If Under 24 Hrs.	8 Date of Birth	Washingto	on place (State or Foreign
	Funeral Director		219-34-7482		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, You (Month, Day, You	ear) Cou	TNT3, MD
	nd v		Usual Residence of Decedent					occumber.		
	faryla shov	ō	10a. State 10b. County MD Washington	10c. City, To Sabil						10d. Inside City Limits 1 □ Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	- 1
	th with 23a or 1st be	al D	16602 BuckLantz F	Rd.		21	780		US	
	tems:	Funeral	The marian orange	Vas Decedent Ever in U.S. Armed Forces?	13. W	las Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
336	rs afte	by F	1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced	12]Yes 21 <b>9]</b> Y18/50— rYes, Give <sup>(ear or Dat9</sup> s/16/54	- 1	□Yes 2∏XNo	Specify:		Specify: whi	te
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show "feal Evarurat rust be notified at	eted	15. Decedent's Educatio (Specify only highest grade co	n 16	6a. Deced	ent's Usual Occup	ation during most of working	16	b. Kind of Business/In	dustry
121	within 7 iene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	) f)		- 11 0	
d 2	filed w Hygie other t		17. Father's Name (First, Middle, Last)		етес	trician	18. Mother's Name		ederal Gov iden Surname)	ernment
au	ld be i lental ked o ic eve	To Be	Robert L. Calimer				Mary Kat			
Maryland	2 should to and Men is marker aumatic	_	19a. Informant's Name/Relationship (Type. I						City or Town, State, Zip	,
	and 2 lealth m 27 i		Helga Calimer			Buck Lan		abillasv:		21780
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evarance must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 🛱 Cremation 3 🖫 Remo 4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other plac d Valley	e) August	: 25 <b>,</b> 200	c. Location - City or To )9 aynesboro ,	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	lossus		Name and Addres	GI	ove-Bowe		al Home, In
			23a. Part Lenter the disease, or complication shock, or heart failure. List only one care	ons that caused the death. D				*	·	Approximate Interval Between
14.	Physician		Immediate Cause (Final disease or condition	agasti.	,C	Can	cer			Onset and Death
-	/Medical Examiner		resulting in death)	Due to ( v s a consequence	ce of):				C	2 //
		Jer	Sequentially list conditions, if any, leading to immediate cause. Entail Underlying Cause (Disease or injury	Due to (or as a consequenc	ce of):					
	ecuted nd ransit	Examiner	that initiated events C.							
60,	tificate be executed g physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequenc	ce of):					
68760,	ificate g phys is the	edical	d							
Box	leath certific attending p	M/U	23b. was decedent pregnant	f yes, outcome of pregnancy □ Live birth 2 ☐ Fetal dea	ath a□	Ectopic pregnancy	,		23d. Date of deliv	ery
P.O. B	ires that the death cei signed by the attendir d be detached for use	Physician/M	1 TVes 2 TNo	☐ Pregnant at time of death ☐ Unknown		Other (specify)	y		Month	Day Year
ď.	s that gned b	by Pr	Part II. Other significant conditions contribu	iting to death but not resulting	g in the un	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
ord	w require s been sig should b	ted						1 🗆 Yes	2 No 3 Pro	bably 4 🗌 Unknown
Šeč	e 2 sh	Completed						24a. Was an autopsy	, prior to co	opsy findings available ompletion of cause of
ā	n: Th ficate r, pag		DE Management to a district					1		2 🗆 No
5	ysicia s certi directo	o Be	25. Was case referred to medical examiner?  1 Yes No Hosp	tal: 1 ☐ Inpatient 2 ☐ ER/0	Outnatient	3□ DOA Othe	26. Place of Death		ce 6 ☐ Other (Speci	60
0	ding Physician: The lav h. After this certificate has funeral director, page 2 s	n: To			o. Time of Injury	28c. Injury Work	y at 2	8d. Describe how		<i>y</i> /
Sio	tendia leath. tor: A the fu	catic	2 Accident investigation			M 1 □	Yes 2 □ No			
Division of Vital Records,	after death after death Director: d in by the	Certification:	4 Homicide determined	Be. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use it.	edical C	(Check only Medical Examiner:	n: To the best of my knowled On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tir estigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner as a e and place, and due t	stated. o the cause(s)
	vithin To th	Me	29b. Signatule and title of certifier	1		29c. License	e number	29d	. Date signed (Month,	Day, Year)
		01	Hullan	udan	MD	DH	6473	A	ugust ?	14, 2009
			30. Name and address of erso who comple	eted cause of death (Item 23a	a) (Type, P	rint)	- 11		3	N.M.
	Sta	te.	31. Date filed (Month, Day, Year)	32. Regintrar's Signature	0 6	DAHC	-1, to	aderva	rown, M	791140
	Registra		AUG 3 1 20	19 Denova	B. 1	parke	,			

DHMH 17 Rev 1/2001

Physicia /Medic Examin

Phys /Me Exar

Fune Direct

		Please	Type or Print in B				_	_	
	-	For State Registrar	State of Maryland		partment of Certificate		Mental Hygie Reg.	00000	27798
icia dica		1. Decedent's Name (First, Middle, La Kenneth Paul	<sup>st)</sup> Durkin				2. Date of Death Month August 12	Day Year	3. Time of Death 12:20 p.m.
ine		4a. Facility Name (If not institution, given Chesapeake Shore	ŕ			wn, or Location of Dea gton Park		4c. County of Dea	
al or		5. Social Security Number 6. S		a <i>st birthda</i> Yrs	ay) If Under 1		s. 8. Date of Birth	ar) 9. Bir	thplace (State or Foreign ountry)
		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or	r Location				10d. Inside City Limits
	irecto	Maryland St. Ma	ary's L	exin	gton Par		10g.	Citizen of What Co	1 ☐ Yes 2 🛣 No ountry?
	eral D	21412 Great Mill	12. Was Decedent Ever in U.S	S. 1		0653 t of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No-	U S A	erican Indian,
	Completed by Funeral Director	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates:		If Yes, specify 1 ☐ Yes 2 1		rtó Rican, etc.)	Black, Whit	e, etc. White
	pleted	15. Decedent's Ec (Specify only highest gra	ade completed)	16a. De	ecedent's Usual C live kind of work of fe. DO NOT use r	Occupation done during most of we retired)	orking 16b	. Kind of Business	
8	e Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last,	College (1-4or 5+)		Plumber		ame (First, Middle, Maid	Plumbing den Surname)	5
	To Be	George F.	Durkin, Sr			Beatr		kstein	
		19a. Informant's Name/Relationship (  Jessica M. Durki			,		Rural Route Number, Ci		
		20a. Method of Disposition 1 ☐ Bunial 2 🙀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	metery, c	sposition (Name crematory or othe	r place)	Date 200 /15/2009 Cl	.Location - City or	
once.		21. Signature of Fune of Service Live	M000	52		Address of Facility Br	insfield F	neral Ho	ome, P.A.
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		enter the mode of	of dying, such as cerdi			Approximate Interval Between Onset and Death
n al er		disease or condition resulting in death)	Due to (or as a consequ	ence of):					day years
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Coronary A  Due to (or as a consequ	ence of):		ase			years
	ш	that initiated events resulting in death) Last	c. Hypertensi  Due to (or as a consequ						years
	Medic	IF FEMALE:	_d						
	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death	3 ☐ Ectopic preg 5 ☐ Other (spec			23d. Date of de Month	elivery Day Year
	ed by Ph	Part II. Other significant conditions of	ontributing to death but not resu	Iting in th	e underlying caus	se given in Part I.	23e. Did tobac		o the cause of death?
	Completed by					<u></u>	24a. Was en autopsy performed 1 □ Yes 2	24b. Were a prior to death?	utopsy findings available completion of cause of
	Be	25, Was case referred to medical examiner? 1 ☐ Yes 2 (No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpa	atient 3 DOA	0.0	eath (Check only one) Home 5 Residence	e 6 □ Other (Spe	ecify)
	Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	28b. Tim Inju	ie of ry M	. Injury et Work? 1 □Yes 2 □No	28d. Describe how i		
	ertifica	3 Suicide 6 Could not b 4 Homicide determined		me, farm,	, street, factory, of	ffice	28f. Location (Stree City or Town, S	t and Number or R tate)	ural Route Number,
	Medical C		hysician: To the best of my know miner: On the basis of examinat and manner stated.						
	<u>≅</u>	29b. Signature and title of certifier			29c. L	icense number	29d.	Date signed (Mon	th. Dav. Year)

R

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101 Centennial St., LaPlata, MD 20646 M.D. Amir Alikhani,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 18 2009

29c. License number 4-604-6

29d. Date signed (Month, Day, Year) 8 \_ 13 \_ 208

			1 _ State	-	Department of F Certificate of		ental Hygie Reg.	0000	07700
			Registrar  1. Decedent's Name (First, Middle, Last)		Cortinioate or		2. Date of Death	100	3. Time of Death
	Physici /Medi		Amelia Marschat	Dennis				Day Year 15, 2009	8:27 a M
and a	Examir		4a. Facility Name (If not institution, give street and nur		4b. City, Town, o	r Location of Death		4c. County of Death	
			24805 Hill Road		Holly			St. Mar	
	Funeral		4 🗆 14 0 📆 🗉	7. Age (In yrs. last birt	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. B Hours Min.	B. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	00	110.		04/13/19	21 Wash	nington, DC
	aryland show		10a. State 10b. County	10c. City, Town				. 1	10d. Inside City Limits
	e Mar 3a-f s	cto	Maryland St. Mary's	Но	11ywood				1 □Yes 2 X No
	ith th	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Coul	ntry?
	s 23a	Funeral	24805 Hill Road	dead Evention III O	2063			USA	1 2 2
10	ter de	Ē	11. Marital Status 12. Was Dece Armed For 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	dent Ever in U.S. ces? 2 <b>XX</b> Io	13. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto Ri	can, etc.)	14. Race - Americ Black, White,	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Expression at the natified at		3 ☑ Widowed 4 ☐ Divorced If Yes, Giv Year or Da	re	1 □ Yes 25€No	Specify:		Specify: Wh	ite
5-0	72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup	pation during most of working	16b	. Kind of Business/In	dustry
121	within ene.	Id III	Elementary/Secondary (0-12) College (1	-4or 5+)	life. DO NOT use retired	<u>a)</u>		0 17	
	filed within Hygiene. <b>xther than</b> '		17. Father's Name (First, Middle, Last)		Homemaker	18. Mother's Name (	First Middle Maid	Own Home	
an	d be i ental ked o	To Be	Louis Marschat			Alice	Curtis		
Maryland	2 should be filed w and Mental Hygie is marked other t aumatic event, th	۴	19a. Informant's Name/Relationship (Type. Print)	19b.	. Mailing Address (Street	and Number or Rural i	Route Number, Ci	ty or Town, State, Zip	o Code)
	<b>T 23</b> 盖 G		Vernon Dennis/Son		24801 Hill F	Rd., Hollyw	ood, MD	20636	
ore	ges 1 and He If item	-	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from §	20b. Place of	Disposition (Name of ry, crematory or other place			. Location - City or To	own, State
ij	nit. Pag artment ortant: I Injury o		4 □ Donation 5 □ Other (Specify)	olale	ngton Natior	na1 08/20/		itland, M	
Baltimore,	permit. Pages 1 a D.partment of Hes Important: If item any Injury or othe		21. Signature of Euneral Service Licensee	Jr. M00052		ss of Facility Brin: lywood Rd.			-
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause, on ea	aused the death. Do n	not enter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	raestine	Heart Fo	reline,			Onset and Death
4-2	/Medical Examiner		resulting in death)  Due to (	or a a consequence o	of):				
	Lxammer	<u>.</u>	Sequentially list conditions, b.	emeration					
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	or as a consequence of	Andres	Diseas	ø		
Ć,	ifficate be executed g physician and as the burial-transit	Еха	that initiated events C.	or as a consequence of	of):	Maeus			_
68760,	tte be iysicia ne bur	edical	d						
		Med	IF FEMALE:			-07-03-0		1 10	
Вох	requires that the death certific seen signed by the attending p nould be detached for use as t	Physician/M	23b. Was decedent pregnant 23c. If yes, out	come of pregnancy irth 2 D Fetal death		y		23d. Date of deliv	ery Day Year
o O	hè de the a	ysic	1 ☐ Yes 2 Mano 4 ☐ Pregri 9 ☐ Unknown 9 ☐ Unknown	ant at time of death own	5 ☐ Other (specify) _		<del></del>	Monar	Day Tour
σ.	res that the de signed by the be detached		Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cause giv	en in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?
of Vital Records	quires n sign	d by					1 □ Yes	2 No 3 Prol	bably 4 🔀 Unknown
တ္တ	~ 17 70	Completed					24a. Was an	24b. Were auto	opsy findings available
Ä	о <del>_</del> о	mo					autopsy performed	?   death?	mpletion of cause of
İta	siclan; The certificate irector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Death (	1 ☐ Yes 2 X Check only one)	,10   1 les	2 🗆 110
<u>&gt;</u>	9 S =	2	1 Yes 2 No Hospital: 1 □ I	npatient 2 ER/Out	·	4 LI Nursing Home	e 5 Residence	6 ☐ Other (Special	fy)
Ë	iding Phy th. : After this funeral c	ion	Tatalan O I on on one		Firme of 28c. Injury Worl	k?	d. Describe how in	njury occurred	
Division	Attending r death. ector: After by the funer	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place	of Injury - At home fau	M 1 ☐ rm, street, factory, office	Yes 2 No	f Location (Ctross	and Number or Rura	al Pouto Number
Θį	after deatl after deatl Director: d in by the	Certification:	4 Homicide determined buildir	ng, etc. (Specify)	ini, street, lactory, office		City or Town, Si		ar rioute Namber,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1.★ Certifying Physician: To the bar and mann and	asis of examination and	e, death occurred at the til d/or investigation, in my d	me, date and place, an opinion, death occurred	nd due to the caus I at the time, date	e(s) and manner as s and place, and due to	stated. o the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier		29c. Licens			Date signed (Month,	
	0		· Pront	)	Moo	5575		8/17/09	9
	V1	1	30. Name and address if person who completed cause	of death (Item 23a) (	(Type, Print)			11/2	
	15				nts Lane, Le	onardtown,	MD 2065	0	
	Sta		31. Date filed (Month, Day, Year) 32. AUG 18 2009.	egistrar's Signature	have				
	Registr	al .	**************************************	un A.	gave		· · · · · · · · · · · · · · · · · · ·		

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09-06595	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legi
Robert Emory Donaldson	State of Maryland / Department of Health and Mental Hygiene
1. For State	0 175 1 55 11

			1- For State Registrar	State of Maryland		tificate of		na monte	, 9.		g. No.	200	19 2780
	Physic	cian/	1. Decedent's Name (First, M	liddle,Last)					I M	ate of Death	n Dav	Year	3. Time of Death
Med	dical Exar	nine	NUDERI EMURI						Αι	ugust 23,	2009	unty of Death	0159 hrs
			4a. Facility Name (if not instit 103 Miller Street	tution, give street and numbe	r)	4	b. City, Town, c	or Location of L	Death		Cec		
	Funera	al l	5. Social Security Number	6. Sex 7. A	ge (In yrs. la	st birthday)	If Under 1 Ye	ear If Under 2	24Hrs. 8.	Date of Birt	n(MM/DD/	YYYY) 9. Birl	thplace (State or Foreign
	Directo		219-17-5229	1 XM 2 F	23	Yrs.	Months Da	ys Hours	Min.	7/3/19	86	Co	untry) MD
	any		Usual Residence of Deceder  10a. State 10b. Cou		10c. City,	Town or Location	on				-		10d. Inside City Limits
1	bu show:	4 5	MD QUE	EN ANNE'S	M:	ILLINGT	ON						1 Yes 2 X No
4	faryla 28a-f	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen	of What Cour	ntry?
do	1 the N	ם		RD.			21651	L			1	USA	
-	th with	Funeral	11. Marital Status  1 X Never Married 2	Married 12. Was Deceder			Decedent of H				14.	Race - Ameri White, etc.	can Indian, Black,
	er dear			Mannea	2 X No		Yes 2X N				Sne	ecify: WH	ITE
	ırs aft tırral"	] A	45 Barrier 11 Education 1	or Dates: Specify only highest grade co	ompleted)	16a. Decedent	's Usual Occup	ation (Give kir		done	خلا	of Business/	
	72 hoy "na" na	Completed	Elementary/Secondary (0-			during mo	st of working lif	fe. DO NOT us	se retired)				
	vithin ene.	a a	9			MECHA	NIC					TOMOTI	VE
	21215-0036 ould be filed within 7 Mental Hygiene.	i o		,				18.Mother's			laiden Sur	name)	
	212 uld be Menta marko	To Be		STUS DONALDSO ionship (Type, Print )	'IN	19b. Mailing	Address (Stre		YL SH er or Rural		ber, City o	or Town, State	e, Zip Code)
	MD 12 sho			ONALDSON/FATH	ER	221 L	EGION R	RD. MIL	LINGI	ON, M	D 21	551	
	imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Intent: If item 25 is marked other than "natural", or items 23a or 28a-f show any content and the Maries Promitted at once the Maries Beautiful at the Maries Bea		20a. Method of Disposition	ation 3 Removal from S		lace of Disposi rematory or oth		cemetery,	Da	te	20c. Loc	ation - City or	Town, State
	Page Page nent o		4 Donation 5 Othe			ESAPEAK	E CREMA	TION	8/26/	2009	STE	VENSVI	LLE, MD
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: (if time 27 is marked other than "matural", or items 23a or 28a-f sho		21. Signature of Funeral Service	10/11/	7 .	22. N F E L	ame and Addre	ess of Facility IELFENB	EIN 8	NEWN	AM FI	JNERAL	HOME
	Physicia		23a. Part I. Enter the disease	1	d the death.	130 Do not enter th	LOWS, H SPEER e mode of dvin	RD, CH	ESTER diac or res	RTOWN .	MD :	21620 or heart	Approximate Interval
	/Medica	1	failure. List only one ca	use on each line.		oxicat		<i>.</i>					Between Onset and Death
	<sup>-</sup> xamine		Immediate Cause (Final dise or condition resulting in deat				1011						
			Sequentially list conditions,	b									
		i e	if any, leading to immediate cause. Enter Underlying Cal (Disease or injury that initiate		sequence or	1:							
	- g	Examine	events resulting in death) La		sequence of	):							
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and romalized Difference as the functor none? A benefit he deached for use as the buries!	E	Xunpended	d. AMENDED 23	a,27,2	28a-f,p	erME, g	895 9/	25/09	TT			-
	60, ate be	Medical	IF FEMALE:	23c. If yes, outc	ome of prean	ancv					23d. D	ate of deliver	V
	687 ertifica ding p	an/l		in the 1 Live birth		2 Fet	al death 3	3 Ectopic p	oregnancy		Мо	onth	Day Year
	Box 68: e death certifi the attending	/sician/	1 Yes 2 No 9		at time of dea	5 Oth	ner (Specify)						3
	iaw requires that the death certifians been signed by the attending	Phys	Part II. Other significant co		ath but not re	sulting in the u	nderlying cause	e given in Part	i.	23e. Did to	bacco use	contribute to	the cause of death?
	res that signed	À						·	_	1 Yes	2 N	o 3 Pro	bably 4 🗸 Unknown
	rds v requi	Completed								24a. Was autop			utopsy findings available completion of cause of
	Che lay	i i								perfor	med? 2 No	death? 1 ✔ Y	es 2 No
	tal Records cian: The law requi	BeC	25. Was case referred to me				26.Pla	ce of Death (C	Check only	one)			
	Physic r this	]   P	1 ✓ Yes 2 No			ER/Outpatient			Nursing Ho			e 6 ✔ Othe	r: Scene
	Division of Vital Records, P.O. lat or Attending Physician: The law requires that the rs after death. The or this certificate has been signed by Joil in by the funces director mass 2 should be deach.	<u>.</u>	27. Manner of Death  1 Natural 5	28a. Date of In (Month, Day		28b. Time of Ir		njury at Work? Yes 2X		l. Describe I $\mathrm{nk}$	iow injury	occurred	
	ivision or Attendafter death Director:	icat	2 Accident	nvestigation FG 8/2.		unk me, farm, stree			28f	Location (S	Street and	Number or R	ural Route Number, City
	Div pital or purs aft eral Di	Certification:	3 Suicide 6 X C	determined (Specify) U	nk				un	pr Town, S	tate)		
	e Hosp 24 ho e Fune	ia O		g Physician: To the best of	my knowledg	je, death occur	ed at the time,	date and place	e, and due	to the caus	e(s) and n	nanner as sta	ted.
	Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I To othe Funeral Director: After this certificate I	Medical	one) 2 Medical	Examiner: On the basis of ex and manner state	amination ar	nd/or investigat			urred at the	time, date			
	-6-	2	29b. Signature and title of ce	O . 11 . 1	4			nse number C.M.E.				e signed <i>(Ma</i> st 23, 2009	onth, Day,Year)
	0		Hunch	TVUIRALL	MI)	230)		Z.IVI.∟.			L	. 20, 2003	
			30. Name and address of per Pamela E. Southat			,	1 Penn Stre	et, Baltimo	ore, MD	21201			
		State		0')5 2000 32. Regist	rar's Signatu		VEN .					_	
	Regi	stra	AUG /	Charles Char	wa,	p. 190	200						<del> </del>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 18, 2009 3:25 p M August Dea1 Mae The 1ma /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 ☐ M 2 🔀 F Virginia 02/15/1926 579-26-3845 83 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2x No Director Lexington Park St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number USA 20653 Funeral 21895 Pegg Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∏Yes 2XXXVo Specify δ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, IT-all once. Engineering Company 12 Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leedv Shifflett Nettie Crawfoed ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 40383 Duke Road, Mechanicsville, MD 20659 Gwen Estep/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/22/2009 Suitland, MD Cedar Hill 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A. 21. Signature of Funeral Service License 0052 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythia - Ventrocular /Medical Due to (or as a consequence of): Examiner hypoxia Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a consectionou off the Hospital or Attending Physician; The law requires that the death certificate be executed end stage COPA sician and burial-trans Due to (or as a consequence of): physician the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide n 24 hours the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier To the Hosp within 24 ho To the Fune completely f Medi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier august 20, 2009 D0068540

State Registrar

DHMH 17 Rev 1/2001

Hospital 25500 32. Fegistrar's Signature

AUG 20 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Mont)

Pt Lookout Rd Leonardtown MO

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		partment of Health and ertificate of Death	Mental Hygier	0000 17000	)
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death	-
	Physicia		Katherine Paulin	ne Eble			Day Year 2:29 p	√I
Mary	/Medic Examin		4a. Facility Name (If not institution, give street		4b. City, Town, or Location of Deat		4c. County of Death	
1	Examini	C.	23254 Nicholson Str	eet	Hollywood		St. Mary's	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	ay) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreignar) Country)	gn
ы	Director		212-28-7142 <sup>1□ M</sup>	21 <b>X</b> F 79 Yrs	Willis Days Hours Will	02/22/193	30 Marylan	
	pu ,		Usual Residence of Decedent	10c. City, Town or	Leasting		10d. Inside City Limit	ts
	aryla shov	'n	10a. State 10b. County	Too. City, Town or	Location		1 □Yes 2 🖾 N	
	ne M	ect	Maryland St. Mar	cy's He	10f. Zip Code	100	Citizen of What Country?	
	a or i	ä	10e. Street and Number			l log.	U S A	
	sath v	Funeral Director	23254 Nicholson St		20636 3 Was Decedent of Hispanic Origin? (	Specify Yes or No-	14. Race - American Indian,	
	item item	F.	11. Walta Olalas	Armed Forces? 1 □Yes 2 ☑ No	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer</li> </ol>	to Rican, etc.)	Black, White, etc.	
38	irs af	by		If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White	
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must ke redified at	Completed	15. Decedent's Education	on 16a. De	cedent's Usual Occupation	16b	. Kind of Business/Industry	
215	hin 7;	ed i	(Specify only highest grade co	College (1-4or 5+)	ive kind of work done during most of wo e. DO NOT use retired)	rking		
21	filed within Hygiene. other than '	Son	12	- 1	Homemaker		Own Home	
pu	be file Ital Hy ed oth	Be (	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygene. I Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar man to reculted an	은	Howard Joseph	DePascal	Gertr			
<b>Jar</b>	2 sh n and rismr		19a. Informant's Name/Relationship (Type.	· 1	ailing Address (Street and Number or F			
	s 1 and of Health item 27 other tr		George Eble/Son  20a. Method of Disposition		P.O. Box 1237, Leo		. Location - City or Town, State	
٥	g = to		1 ☐ Burial 2 🖾 Cremation 3 ☐ Rem		sposition (Name of strematory or other place) ald-Echols 08/1		Charlotte Hall, MD	
Baltimore,	- F F F		4 □ Donation 5 □ Other (Specify)  21. Simulation of □ Sicense	BITHSIT		0/2000	Funeral Home, P.A.	
Ba	permii Depar Impor any ir once.		Edward N. Brinsfie	eld Jr. M00052	22955 Hollywood R			
П			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	ions that caused the death. Do not ause on each line.	enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate interval Between Onset and Death	
I have	Physician		Immediate Cause (Final disease or condition	Cerebrovascu	lar Accident		Offset and Death	
الران	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	LXaiiiiiei	-	Sequentially list conditions, b. =	Due to (or as a consequence of):				
	ted nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence or).				
,	execun and all-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of):				
58760,	icate be executed physician and the burial-transit	dical	d					
_	tificat ig phy as th					0/38	-	
Вох	eath certific attending p	N.	23b. was decedent pregnant	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery	
	deat he att ed for	Physician/M	in the past 12 months? 1 □Yes 2 MNo	4 Pregnant at time of death	5 Other (specify)		Month Day Year	
P.0	at the ded by the stached	Phy	9 Unknown		and delice and a line in Death	230 Did tobac	co use contribute to the cause of death?	
S,	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	þ	Part II. Other significant conditions contrib Hypertension, Hyper		e underlying cause given in Part I.		2XXNo 3 Probably 4 Unknow	wn
of Vital Records,	w requir been s should	Completed	ilypercension, ilyp	CI II PIGO MIG		-		
Sec.	e 2 sl	nple				24a. Was an autopsy performed	24b. Were autopsy findings availat prior to completion of cause of death?	of
e E	: The licate h	ပ္ပ				1 □Yes 2 🔀		
V:	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	pital: 1 tient - 0	Other:	eath (Check only one)		
<b>5</b>	Phys this ral dir	은	To res ZXIIIO	1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of Injury 28b. Tim	Itlefit 3 DOA 4 Nursing	Home 5½ Residenc	e 6 Other (Specify)	
o	ding h. After fune	ë	1 X Natural 5 ☐ Pending	(Month, Day, Year) Inju		250, 2505, 25 1,617	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division	or Attending after death. Director: After In by the fune	fica	3 Suicide 6 Could not be	l 28e. Place of Injury - At home, farm		28f. Location (Stree	et and Number or Rural Route Number,	
<u>S</u>	after after I Direct	Certification: To	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S	rare)	
	To the Hospital or within 24 hours after To the Funeral Diruccompletely filled in I		29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examiner	: On the basis of examination and/	eath occurred at the time, date and pla or Investigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
	To the I within 2 To the I complet	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	. Date signed (Month, Day, Year)	
_	<b>₹</b> ₹ 8			attendi	D0055682		08/17/2009	
	6		30. Name and address of person who comp		A		00/11/2007	
	8.2		Thomas M. Wilkins	on, M.D. 23140	Moakley St., Leona	rdtown, MD	20650	
	Sta		31. Date filed (Month, Day, Year) AUG 20 2009	32. Registrar's Signature	bares			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Comparison Name   First Matths (Last)   Comparison   Co				For State Registrar	State of Mai	ryland		artment rtificate			and M	F	Reg. No.	09	278	03
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Secretary Control   Secretary Number   Secretary				4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death					
Company   Comp		A.						1			OA Hee	0.5-1-1514				F* i
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The state of the s		Director			60	)	113.					Aug. /	, 1949	<u>I</u> \	i C	
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Part   The part   Th		deat	ner	11. Marital Status	12. Was Decedent Ev	ver in U.S	3. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	acify Yes or No- Rican, etc.)	14. R			
Part   The part   Th	9	after or its			1 ☐ Yes 2 No	)								cifv:		
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Day Service of the control of the co	Σ	shoul mari	F		ype, Print)		19b. Mailir	ng Address	(Street a				er, City or Tox	vn, State, Zip	Code)	
State   Contention   Commonwealth   Content				Audrey Liggins-Da	aughter		5439	Addis	on F	Rd.	Capi	tol Hei	ghts,	Md. 20	743	
23. Part. Eries the disease, or complications that caused the death. Do not emiter the mode of giving, such as cardiact or respiratory arrest, shock, or hearffathurs. List only one cause on each line.  Physician / Medical Examinor  Approximate the disease, or complications that caused the death. Do not emiter the mode of giving, such as cardiact or respiratory arrest.  Physician / Medical Examinor  Sequentially list conditions.  If you so for as a consequence of):  Due to (or a	ē	K Hee		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Nan	ne of	1	1	Date	20c. Locatio	n - City or To	own, State	
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Physician / Medical Examiner / M	œ	80 1 8		Dulle	· XXXX	m	43	308 St	iitla	ind R	d.	Suitlan	d, Md.	20746	,	
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OC TO SET IN THE PROPERTY OF T	.09289	icate be executed physician and s the burial-transit	cal	that initiated events	c											
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26. Place of Death (Check only one)  27. Manner of Death  1 Natural  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Describe how injury occurred  28. Place of Death (Check only one)  28. Describe how injury occurred  1 North Day Year  28. Place of Death (Check only one)  28. Describe how injury occurred  1 North Day Year  28. Describe how injury occurred  1 North Day Year  28. Describe how injury occurred  1 North Day Year  28. Describe how injury occurred  1 North Day Year  28. Describe how injury occurred  28. Describe ho			ed by P	Part II. Other significant conditions co	ontributing to death but	Und	Ilting in the u	inderlying o	ause give	en io Part	n and	0			1.	1
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The state of the s	5	hysic his ce I dire	2		Hospital: 1 Inpatien	t 2 🗆 l			OA Oth	9r: 4 □ Nu	ursing Ho	me 5 Resi	dence 6 🗆	Other (Speci	fy)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and dident occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature.	<u>_</u>	ing P Mer t Inera	ë :		28a. Date of Injury (Month, Day	Year)			Worl	k?		28d. Describe	how injury oc	curred		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and dident occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature.	Sio	tendi leath. tor: A	cati	E - Mooidont				-		Yes 2 ∐	No	004 1 /	Care at and ble	umbas as Out	ol Courte Mu	
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2 2 State 31. Date filed (Month, Dey, Year) 32. Registrar's Signature:  1		pital ours 6 ierai I		29a. Certifier 1 Certifying Phy	vsician: To the best of	f my knov	wledge deal	th occurred	at the tin	ne, date ar	nd place	and due to the	cause(s) and	manner as	stated.	
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State 31. Date filed (Monati, Dey, 19ar) 32. Hegistar's Signature	2	2		30. Name and address of person who co	ace MD 4	ath (Item	23a) (Type	Print)	EV.	Rd 1	-1 ya	+ tsvill	e Mi	20	781	
					32. Registra	r's Signal	ture		1							

Registrar

State

31. Date filed (Month, Day, Ye AUG 18 2009

29b. Signature and title of certifier

29a. Certifier

Medical

Fisehatsion Mehari, M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064478

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Fo1tz 10:30AM E1wood Pau1 August 18. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Months Days Hours 89 Yrs Director 225-05-1133 December 3, 1919 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be realised at St. Mary's Piney Point 1 ☐ Yes 2 X No Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code be filed within 72 hours after death with ntal Hygiene. 45330 Stark Drive 20674 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 14. Race - American Indian. Black, White, etc 1 Never Married 2X Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government 10 Firefighter permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other any Injury or other traumair. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Glyndon Paul Foltz Bertha Fiddler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lena Alice Foltz / Wife 45330 Stark Drive, Piney Point, MD 20674 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 22 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 Charles Memorial Gardens 21 Structure of Euneral Service Licen 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocard **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Lew than Examiner Reverato day Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine signed by the attending physician and deetached for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> cate has been si page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 1 ☐Yes 2.250No 1 ☐ Yes 2 **X**(10 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be

P.O. Box 68760, Division of Vital Blwood

Baltimore, Maryland 21215-0036

VD

State

Medical

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

determined

C Gaby

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D54346

Holly wood

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M-D.

Shah

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last 3 Time of Death Month **Physician** /Medical Name (If not institution, give street Town, or Location of Death Examiner Po oma Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** Days 1 🗆 M .15 Director Russia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Yes 2 No Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code U.S.A. death Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ΜŅο Specify: þ 4 Divorced 3 Widowed Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Radio Producer Voice of America 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria (unknown) Yevgeniy Rabuchin ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lydia V. Hofer - Daughter 151 D Street, SE, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 x Removal from State 4 Donation 5 Dother (Specify) Rock Creek Cemetery 08/17/2009 Washington, D.C. 22. Name and Address of Facility 21. Signature Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904 11800 New Hampshire Avenue, Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure. ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 2 m 4☐Pregnant at time of death 5 Other (specify) No 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 Yes 2 or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director, Be 26. Place of Death (Check only one Other: 4 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Peath 28c. Injury at Work? Medical Certification: After (Month, Day Year) Injury Maturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital 3 0

> State Registrar

29b. Signature and title of certifier

30. Name and address

Loreto S. Albiol, M.D., 8218 Wisconsin Avenue, Suite 305, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) AUG 17 2009

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per phys. 6895 9/1/09 dk
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) 449 Month Year **Physician** Bryten Cole Fairbanks 2009 August 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday, **Funeral** Months Hours 1 □**x**M 2 □ F N/A 3, 2009 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County at 1 Yes 2 No or 28a-f sl notified Director MD Dorchester Federalsburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 5 pe United States 21632 23a 6731-2 Bailey Store Road Funeral ral", or items 23: Examiner must Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status N / A d 2 □ Married Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 2 No 1 Never Married Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2x No Specify. White þ 3 Widowed 4 Divorced ed other than "natural", event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Autumn LaRay Latta James Fairbanks ပ 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6731-2 Bailey Store Rd., Federalsburg, MD 21632 Autumn L. Fairbanks/Mother permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Unity-Washington Cem. 08/21/09 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Houle Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disseminate Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) iding physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 🗌 No 2 | No 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 ☐ Yes 2 🔼 No Other:  $_{4}$   $\square$  Nursing Home  $_{5}$   $\square$  Residence  $_{6}$   $\square$  Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 27. Mann red eath Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After tilled in by the funer 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 
Suicide Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

hours after death within 24 hours a

To the Funeral D

completely filled

> State Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier,

33 Registrar's Signature 31. Date filed (Month, Day, Year)

cker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** August Goth 2250 byce 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** None The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** Days Hours WI 1 M 2 X 79 **Director** 12/5/1929 391 26 4728 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 Yes 2 No Director MD Howard Ellicott City 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō Funeral 2980 Normandy Dr. 21043 Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 TYes 2 X No ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify Specify: White Š 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) other than and Mental Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hjalmer Nelson Nanny Nelson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.9 Department of Health ar Important: If item 27 is any injury or other trauonce. Robert W. Goth, Jr. / Son 2984 Normandy Dr., Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State Mt. View Cemetery 8/15/2009 Marriottsville, MD 5 Other (Specify 4 Donation 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc 21. Signature of Funeral Service Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respitory failure
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Interstitial luna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Prevnonia The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jass 2 🗌 No 2/ No 1 Yes Yes certificate | or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Director: After Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident hours after death filled in by the Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier RES-000 1avanya navin E.G. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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32. Re

istrar's Signature

Breun

600 North Wolfe St, Baltimore, MD, 21287

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of ivid	ii yiai i		artment of i			Reg. No.	2009	27809
	Physicia	an		ne (First, Middle, La						2. Date of De Month	Day	Year	3. Time of Death
-	/Medic	al	4a. Facility Name (		Gorozdos ve street and number)			4b. City, Town, o	or Location of Dea			009 County of Death	11:05 a <sup>M</sup>
-6.					at Riderwood V			) If Under 1 Year	Silver	Spring	*la		George's
ı	Funeral Director		5. Social Security N 346–22–57	41	Sex 7. Age 1 I M 2 I F	81	ast birthday, Yrs.	Months Days	Hours Min		1928 <sup>)</sup>	Il III	
	/land		Usual Residence o 10a. State	10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limits
	e Mary	Director	Maryland	Prince Ge	eorge's		Silv	ver Spring					1 □Yes 2 No
	th with th	al Dire	10e. Street and Nu 3152 Grad	umber <b>cefield Ro</b> a	ad, #610			10f. Zip Code	20904		10g. Citiz USA	en of What Cou	ntry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If the mary is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Marchal Evan in the Least be multiled at once.	d by Funeral	11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2 Married 4 Divorced	12. Was Decedent E Armed Forces? 1 ★ Yes 2 □ N If Yes, Give Year or Dates:		S. 13.	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No rto Rican, etc.)		4. Race - Ameri Black, White, Specify:	
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and	ld be filed ental Hyg ked othe ic event,	To Be C		(First, Middle, Last h Stefan Go					1	me (First, Middle Marie Kol		Surname)	
Maryland	nd 2 shou alth and M 27 is mar ir traumat			Name/Relationship			19b. Mail 31	ing Address (Street 52 <b>Gracefie</b>	and Number or F 1d Road, #	Bural Route Numb	er, City or er Spr	Town, State, Zi ing, MD 20	p Code) 0904
Baltimore,	Pages 1 a ent of Hea nt; If item ry or othe				☐Removal from State	1		osition (Name of ematory or other pla an <b>Cremator</b>	ce) Aug	Date ust 15, 2009		eation - City or To	,
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	ath cer attendin or use	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2	2 months? □ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at	2 🗌 Fetal	death 3	□ Ectopic pregnan	су		2	3d. Date of deliv	very Day Year
9.	that the de ned by the a detached f	Phy	9 ☐ Unknowr		contributing to death bu	ıt not resu	ulting in the u	underlying cause gi	ven in Part I.	23e. Did 1	tobacco us	se contribute to	the cause of death?
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ta	lan: Th	Be Co	25. Was çase refe	rred to medical					26. Place of De	1 □Yes	2 <b>☐</b> No	1 □Yes	2 □ No
کر کر	Physician: The la r this certificate ha ral director, page 2		examiner? 1 ☐ Yes 2 ☐					ent 3 DOA Ott	ner: 4 Nursing	Home 5 ☐ Resi	dence 6		ify)
_	The The	tion:	27. Manner of Dea 1 Natural 2 ☐ Accident	ith 5 ☐ Pending investigatio	28a. Date of Inju (Month, Da)	ry v, Year)	28b. Time of Injury	Wo	ry at rk? ]Yes 2 □ No	28d. Describe	how injury	occurred	
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	De Place of Inju	iry - At ho :. (Specify	me, farm, st	treet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Rui	ral Route Number,
	e Hospita n 24 hours e Funeral letely fille	Medical C	29a. Certifier (Check only one)	1⊠ Certifying P 2□ Medical Exa	hysician: To the best of the basis of the basis of and manner sta	examina	wledge, dea tion and/or i	th occurred at the to nvestigation, in my	ime, date and plac opinion, death occ	ce, and due to the	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	1/1/200		2000	29c. Licen	se number		29d. Date	e signed (Month,	, Day, Year)
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_			Andrew Ki	indrat, MD	3110 Gracei			Silver Spri	ng, MD 2090	04			
	Sta Registr		31. Date filed (Mor	nth, Day, Year)	37. Registra	ar's Signa	Jure -	under					

Mauricio 09-05629 Granados

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		State of Maryland / Dep For State	ertificate of		d Mental		eg. No.	000 2701
Physician		egistrar . Decedent's Name (First, Middle,Last)				2. Date of Dea Month		3. Time of Death
ledical Examine	er	Mauricio Granados				July 18, 2	009′	1100 nrs
		la. Facility Name (if not institution, give street and number) 9404 Falls Road	4	b. City, Town, or Potomac	Location of De	eath	4c. County of Montgom	
Funeral Director			. last birthday)	If Under 1 Yea  Months Days		Min.	,	9. Birthplace (State or Foreign <sup>Country)</sup> El Salvado
	-	None 1 M 2 F	32 Yrs.			04/2	4/1977	
w any		0a. State 10b. County 10c. Ci	ty, Town or Location					10d. Inside City Limits  1 XYes 2 No
aryland 8a-f show at once	ġ.	Md Montgomery S	Silver Sp	oring 10f. Zip Code			10g. Citizen of Wh	
the Mar	Director	4502 Mahn Rd.		2090	6		El Sal	-
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f sho late event, the Medical Examiner must be notified at one.	- I	11. Marital Status 1 Never Married 2 X Married Armed Forces?	If Ye	s Decedent of His es, specify Cubar	spanic Origin? n, Mexican, Pu	( Specify Yes or Nerto Rican, etc.)	14. Race White	- American Indian, Black, e, etc.
after de	by Fu	3 Widowed 4 Divorced If Yes 2 X No	1 X	Yes 2 No	specify: E]	L Salvado		Hispanic
hours a		15. Decedent's Education (Specify only highest grade completed)		t's Usual Occupa ost of working life			16b. Kind of Bus	siness/Industry
36 uin 72 l e. than "dical J	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9th	1	Labor			Moving	Company
5-00 ed with lygiene other	ᇹ	17. Father's Name (First, Middle, Last)				lame (First, Middle,	Maiden Surname)	)
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", cevent, the Medical Examiner	å	Vicente de Jesus Granados Sec				a Ines Ay		ranados n, State, Zip Code)
more, MD 21218 Pages 1 and 2 should be file ent of Health and Mental Fr it. If item 27 is marked r other traumatic event, it	٦٩	19a. Informant's Name/Relationship (Type, Print )  Veronica Bermudez/Wife				er spring		
e, N L and Z Health Fitem Z	- 1		o. Place of Dispos crematory or oth		metery,	Date	20c. Location -	City or Town, State
MOF Pages rent of ant: 11		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify	General	Cemeter		08/31/09		alvador
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licens	2 / ///					neral home 3005
Physician	+	23a. Part I. Enter the disease, or complications that caused the dea	th. Do not enter the	he mode of dying	, such as card	nington D	rest, shock, or hea	art Approximate Interval
/Medical		failure. List only one causé on each line.  Immediate Cause (Final disease a. Drowning						Between Onset and Death
`xaminer		or condition resulting in death)  Due to (or as a consequence	e of):					
	<u>ĕ</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):					
0	EΙ	cause. Enter Underlying Cause (Lisease or Injury that Initiated events resulting in death) Last Due to (or as a consequence	e of):					
		d	20 - 5 -	ME 0	) OF 071	0/00 mm		
D, be exe sician a	edical	A ONFENDED	,28a-f,p	er ME G		.0/09 11		
Box 68760, re death certificate be earth the attending physician red for use as the burian		IF FEMALE: 23c. If yes, outcome of proceedings of the second of the seco		etal death 3	Ectopic pr	egnancy	23d. Date of Month	delivery Day Year
cath certificate eath certificate eath certificate eath for use as the for use as the	Physician/N	past 12 months?  4 Pregnant at time of	death 5 Ot	ther (Specify)			0	
D. Bc t the dea	ᇍ	Part II. Other significant conditions contributing to death but no	ot resulting in the u	underlying cause	given in Part I	. 23e. Did	tobacco use contr	ribute to the cause of death?
P.O.	Š						es 2 🗸 No 3	Probably 4 Unknown
of Vital Records, ug Physician: The law requir ther this certificate has been s meral director, page 2 should	Completed						opsy	Were autopsy findings available prior to completion of cause of
Reco	티					per 1 ✓ Yes		death? ✓ Yes 2 No
tal Rectan: The certificate ector, page	Bec	25. Was case referred to medical examiner?			Othor	neck only one)		
Physic r this or	의	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2  27, Manner of Death 28a. Date of Injury	ER/Outpatient		Other <sub>4</sub> N	lursing Home 5	Residence 6 e how injury occurr	
on of anding Ph. th. : After t	<u>ë</u>	Natural 5 Pending Fd 7/18/09	1		Yes 2 XN			_
Division tal or Attendir rs after death. al Director: A led in by the fu	icat	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A				28f Location	(Street and Numb	per or Rural Route Number, City
Division septial or Attent hours after death uneral Director: y filled in by the	Certification:	4 Homicide determined (Specify) River					State)9404 ac, MD	
0 0		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination	ledge, death occu n and/or investiga	rred at the time, of	date and place in, death occur	e, and due to the ca rred at the time, da	use(s) and manne te and place, and o	r as stated. due to the cause(s)
To the within To the To the comple	Medical	and manner stated.  29b Signature and title of certifier			se number	<u> </u>		ned (Month, Day, Year)
~~		Marie Mackage		0.0	.M.E.		July 19, 20	009
	}	30. Name and address of person who completed cause of death (I						<del></del>
		Margarita Korell MD. Assistant Medical Exam		Penn Street, E	Baltimore, I	MD 21201		
Sta Registr	ate	31. Date filed (Month Cay Year) AUG 26 2009 32 Registrar's Sign	A dar	Ked.				

09-06368 Ch

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	State of Maryland / Department of Health and Mental Hygiene

Charles Albert Gra	•	So-For State	tate of Maryla	and / Depa <i>Cel</i>	artment of rtificate of	Health Death	and	Menta	ıl Hygi		lea. No.	"	00 2721
Physiciar	_	egistrar I. Decedent's Name (First, Midd	die,Last)						2.	Date of Dea	ath	Year	3. Time of Death
Medical Examin		Charles Cray Sr Charles Elbert Gray August 14, 2009											
{		ia. Facility Name (if not instituti	ion, give street and nu	umber)	4	b. City, Tov		ocation of I	Death		- 1	County of Deat	
		III HORE OF 3340 Bears Orderories 11 toda				Churchton					1		rthplace (State or
Funeral	- 1	5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under Months	1 Year Days	If Under 2	24Hrs. 8 Min.			Forei	gn
Director	- [2	217-52-2879	1 X M 2 F		59 Yrs.		Dujo ,			Aug	21	1949 0	Märyland
		Usual Residence of Decedent		Ino City	, Town or Locati	ion		-					10d. Inside City Limits
w any		Toa. State		100.00									1 Yes 2 X No
land -f sho	֓֡֞֝֞֡֞֜֞֡֓֓֞֞֜֞֡֡֓֞֜֞֡֡֡֞֜֞֡֡֡֡֡֡֡֡֡֡֡׆	aryland Anne	. Arunde.		Churcht	10f. Zip C	ode				10g. Citiz	en of What Cou	untry?
Mary Hary	<u>e</u>	Usual Residence of Decedent 10a. State 10b. County aryland Anne 10e. Street and Number 5348 Deale	hurchtor	n Rd.			073	3				USA	
th with the Mar	밁	11. Mantal Status	12 Was De	ecedent Ever in U	IS 13 Wa	s Decedent			n? (Spec	ify Yes or N		14. Race - Ame	rican Indian, Black,
ath wi	Funeral		Married Armed F	Forces?	If Y	es, specify	Cuban,	Mexican, F	Puerto Ri	can, etc.)		White, etc.	
or i		3 Widowed 4 XD	1 Yes Divorced If Yes, Give Ye	2X No ear	1	Yes 2X	No	specify:				Specify: B]	
urs af tural	좕	15. Decedent's Education (Sp	or Dates:		16a. Deceder	nt's Usual O	ccupatio	on (Give ki	nd of wor	k done		and of Business	
72 ho n "na al Ex	ompleted	Elementary/Secondary (0-12	′	(1-4 or 5+)						-,		vironn	
5-0036 lled within 7 Hygiene. I other than	립	11th	0		Se	elf E				irst, Middle		cycler	
5-0 iled w Hygid Jothe	ပ၂	17. Father's Name (First, Midd					1						
2121 ould be fil Mental H marked ic event,	8	James D. Gr 19a. Informant's Name/Relation			19b. Mailin	a Address	(Street	and Numb	or et per or Rui	ta B	umber, Ci	ity or Town, Sta	te, Zip Code 2 1 4 0 1
MD 2 d 2 shoul Ith and N n 27 is m aumatic	- 1	Ayesha Karre		nter)									
and 2 lealth tem 2		20a. Method of Disposition	.cm(baagi				of cem	netery,	, ,	Date	20c.	napoli Location - City	or Town, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tani: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		1 XBurial 2 Cremati		from State E1	crematory or of crematory or of			1	8-2	2-09	Ga	lesvi1	le, Md.
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If them 27 is m injury or other traumatic.		4 Donation 5 Other 21. Signature of Funeral Servi		1								y, P.A	
Ba perm Depa Impe	1	7 1 11 11	Page - Dec	483	82	21 We	st	St.	Ann	apol:	is,	Md. 21	401
Physician		23a. Part I. Ever the disease,	r complications that	caused the deal	th. Do not enter	the mode of	dying,	such as ca	rdiac or r	respiratory a	arrest, she	ock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cau Immediate Cause (Final disea	Urmont	ens <b>ive</b>	atheros	cleor	tic	card:	iova	scu1a:	r dis	sease	Death
( :aminer		or condition resulting in death		a consequence									
		Sequentially list conditions,	b.	s a consequence	of):								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause.	se	s a consequence									
_ =	xan	(Disease or injury that initiated events resulting in death) Las		s a consequence	of):	-							
(0, e be executed ysician and burial - transit			d.	#1, 23 #1, per	a.PII.2	7.per	mE .	g895	9/2	8/09	TT		
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Division of Vital Records, P.O. Box 6876( Hospital or Attending Physician: The law requires that the death certificate haurs after death. Funeral Director: After this certificate has been signed by the attending phy lely filled in by the funeral director, page 2 should be detached for use as the U.	ian/M	IF FEMALE: 23b. Was decedent pregnant in	- 4b -	s, outcome of pre e birth		etal death	3 [	Ectopic	pregnan	су		Month	Day Year
Box 6876 e death certificate the attending phy	icia	past 12 months?		gnant at time of	death 5 C	Other (Spec	ify)						
Bo e deat the at the at ed for	Physicia		hammed a	known		1 1 1		iven in Do	et 1	23e Di	d tobacco	use contribute	to the cause of death?
.Ohat th	by P	Part II. Other significant con		g to death but no	t resulting in the	unaenying	cause g	jiveii iii ra		1			Probably 4 🗸 Unknown
S, P uires 1 Id be		Cocaine us	<u> </u>							24a. W	as an		autopsy findings available
ord w req as bee	plet										itopsy erformed?		to completion of cause of 1?
Rec The la	Completed										es 2	No 1 <b>✓</b>	Yes 2 No
tal Records cian: The law requi certificate has been ector, page 2 should	Bec	25. Was case referred to med examiner?	Hospital:			-	-	of Death Other		Home 5	Desig	dence 6 🗸 O	ther: Scene
F Vital Reco Physician: The la r this certificate h	70	1 ✓ Yes 2 No	1	Inpatient 2	ER/Outpatie		OA Iniu	ry at Work				jury occurred	iller. Scelle
n of ding Ph		27. Manner of Death  1 X Natural 5 P	Pending 26a. Da	ate of Injury onth, Day,Year)	20b. Title 0	i injury		Yes 2				, ,	
Sion Attended death sctor:	cati		nyeetigation	lace of Injury - A	t home farm str	reet factory				28f. Locatio	on (Street	and Number of	Rural Route Number, City
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ospits		4 Homicide 29a. Certifier	Dh. staines To the I	hast of my know	edge, death occ	curred at the	time, d	ate and pla	ace, and	due to the	cause(s) a	and manner as	stated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only one) 2 Medical	Examiner: On the bas	sis of examinatio	n and/or investig	gation, in my	opinior	n, death oo	curred a	t the time, d	ate and p	lace, and due t	o the cause(s)
To wit	Mec	29b. Signature and title of cer	and manne	o stateu.				se number			290	. Date signed	(Month, Day, Year)
		Dun	)	$\sim$			O.C.	M.E.			Αι	ugust 15, 20	009
		30. Name and address of per			tem 23a)								
MAD 0.		Donna M. Vincenti,		nt Medical Ex		11 Penn	Street	t, Baltim	ore, M	D 21201			
	tate		26 2009 32	. Registrar's Sigr		back	,						
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in David He		1.	For State	or Maryland		ficate of					Reg.	No. * 1	10 Time of Doorly ( )
Physic		/ 1	. Decedent's Name (First, Middle,Last							I M	ate of Death Nonth D Ugust 15, 2	ay Year	3: Time of Death / 011
edical Exan	nın		John David Heis  a. Facility Name (if not institution, give			<sub>[</sub>	4b. City, To	own, or Lo	cation of D		Jg05t 10, 2	4c. County of Dea	ath
			2468 Hanover Court	ou ou and manner,			Waldo	rf				Charles	
Funera	al		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. las	t birthday)	If Under		If Under 2		Date of Birth	MM/DD/YYYY) 9. E	Birthplace (State or eign
Directo		<b>—</b>		M 2_F	34	Yrs	Months i.	Days	Hours	Min. N	ovembe	r 4,1974 1	Provida
á			10a. State 10b. County 10c. City, Yown or Location									10d. Inside City Limits	
pu pow s	ij	ا چ	Maryland Charl	es		Waldo	orf						1 Yes 2XX No
faryland 28a-f show any	at on	~ _	10e. Street and Number		10f. Zip Code					10g	. Citizen of What Co	ountry?	
the N	otified		2468 Hanover Cou					0601		0.10	<u> </u>	U.S.A.	erican Indian, Black,
th with	t pe u		11. Mantal Status 1 X Never Married 2 Married	12. Was Deceden Armed Forces	?	13. Wa	as Deceder Yes, specify	nt of Hispa y Cuban, I	Mexican, P	rento Rica	y Yes or No- an, etc.)	White, etc.	
er dea	r mus			1 X Yes 2 If Yes, Give Year	No	1	Yes 2	X No	specify:			Specify: Wh:	ite
ours aft	amin	à P	15. Decedent's Education (Specify o	or Dates:	mpleted)	16a. Decede	nt's Usual (	Occupatio	n (Give kin	nd of work	done	16b. Kind of Busines	ss/Industry
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	ca Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		ons S					Militar	-v
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Med	ᆰ	17. Father's Name (First, Middle, Last	4		weap	ons s				st, Middle, Ma	aiden Surname)	. 9
e filed	ıt, the	Be C	David Earl Heisle									. Hallett	
212 ould b d Men	ic eve		19a. Informant's Name/Relationship (			100						er, City or Town, St	
MD d 2 sh llth an	auma		Kirk Heisler/bro	her	Jack D	3600 lace of Dispo						each, MD	or Town, State
Baltimore, MD bermit. Pages 1 and 2 sho Department of Health and Important: If item 27 is	her tr		20a. Method of Disposition  1 Burial 2 X Cremation 3	Removal from S	tate C	rematory or o	ther place)			8-18 <sup>Da</sup>	·2009		e Hall, MD
Limo L. Page tment	or of	ļ	4 Donation 5 Other Specify		Bri MOO8	nsfiel							
Ball permit Depar	injur	1	21. Signature of Funeral Service Loc	19	1.000	17	Brins P.O.	sfiel Box	d-Ect 128 (	hols Charl	Funera otte H	l Home, Fiall, MD 2	0622
Physicia	an	$\dashv$	23a. Part I. Enter the disease, or com failure. List only one cause on e	olications that cause	d the death.	Do not enter	the mode of	of dying, s	uch as car	rdiac or re	spiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/ <u>Ladic</u> tamin	_	1	Immediate Cause (Final disease a	Intraoral Shotg									Death
	ı		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):										
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760, cate be execut physician and	burial -	Medical	UNPENDED	AMENDED								Look But of the	
3760, ficate b g physia	s the b		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outc	ome of pregi		etal death	3	Ectopic	pregnanc	у	23d. Date of deli Month	Day Year
Box 687 e death certific the attending p	for use as t	sician	past 12 months?	4 Pregnant	at time of de		Other (Spe	ecify)				1	li li
. <b>Bo</b> he deal	eq	Phys	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 Olikilowii	oth but not re	sculting in the	underlying	n cause o	iven in Par	rt I.	23e. Did to	bacco use contribut	e to the cause of death?
P.O.	be detach	þ	Part II. Other significant conditions	contributing to dea	att. but not re	socially in the	o and only me	9 9			1 Yes	2 V No 3	Probably 4 Unknown
rds, require been sig	d plnods	Completed				-					24a. Was a		re autopsy findings available r to completion of cause of
COF	71	mple.									perfor	med? deat	
<b>tal Re</b> crian: The certificate	director, page		25. Was case referred to medical					26.Place	of Death (	Check onl			
of Vital Records, ng Physician: The law requir ther this certificate has been s	direct	To Be	examiner?	Hospital: 1 Inpa	tient 2	ER/Outpatie		DOA	Other <sub>4</sub>	Nursing I		Residence 6 🗸 0	Other: Scene
Of ing Ph	funeral		27. Manner of Death	28a. Date of In (Month, Day Aug 15, 200	njury (Xear)	28b. Time o	of Injury		ry at Work? ∕es 2 ✔	lsı	8d. Describe f ubject sho	now injury occurred t self	
ivision or Attend after death. Director:		catic	1 Natural 5 Pending 2 Accident Investiga				reet factor				8f. Location (S	Street and Number of	or Rural Route Number, City
Division tal or Attendii rs after death.	ed in by	Certification:	3 ✓ Suicide 6 Could no determin	it be			root, raotor	,, ooo 2	u		or Town, S		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled		29a. Certifier	nian. To the heet of	my knowled	ge death acr	curred at th	e time, da	ate and pla	ice, and di	ue to the caus	se(s) and manner as	s stated.
To the within To the	compl	Medical	(Check only one) 2 Medical Examin	er:On the basis of earth and manner state	xamination a	ind/or investi		9c. Licens		Curred at t			(Month, Day, Year)
		Σ	29b. Signature and title of certifier	// M	7>		25	O,C.I				August 15, 2	
			30. Name and address of person wh	completed cause of	of death (Item	1 23a)							
* C	)			Assistant Medic			Penn S	street, E	Baltimore	e, MD 2	1201		
$\overline{}$	S	ate	31. Date filed (Month, Day, Year)	ana a	trar's Signat	d. de		0				· ·	

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 16, 2009 Day  $P_M$ **Physician** 4:30 William Guy Herbert, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's 24820 Iron Horse Hollywood Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) April 22,1924 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 X M 2 □ F 218-14-3293 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at any Injury or other traumatic event, the Medical Examinat must be notified at any once. 1 ☐ Yes 2 X No Director Maryland Hollywood St. Mary's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20636 USA 24820 Iron Horse Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☒ No Specify. Specify: <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Architect of the Janitor Capito1 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Nettie Henrietta Guy Hubert Smiley Herbert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24820 Iron Horse Lane Hollywood, MD 20636 Agnes Juanita Herbert / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John's Catholic 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State August 20 Hollywood, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 206 21. Signature of Funeral Service Lice 4 Leonardtown, MD 20650 23a. Parfi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** henson 21 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ × No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 100 1 ☐ Yes 1 □Yes 2 L Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check oply one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Vary er of Lath funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. pesoribe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No Accident 24 hours after death e Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifyin hysician: To re best knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 defical Examiner: O of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one)

State Registrar

31. Date filed (Month, Day, Year) **AUG 18** 

Boyd, M.D.

Name and add person who completed cause of Leath (Item 23a) (Type, Print)

29b. Signature and title of certifi

James C



41600 Bessie Drive Ste. 301 Leonardtown, MD 20650

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 18 per fh, G895, 9/2/09, WS
State of Maryland? Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death
Reg. No.

1. Decedent's Name (First, Middle, Last)
Amy E. Hayes

4a. Facility Name (If not institution, give street and number)

All Copies Are Legible.

Reg. No.

2. Date of Death Month Day Year

8 13 2009

4c. County of Death
4c. County of Death
4c. County of Death
4c. County of Death
4c. County of Death

Funeral

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantual to rother traumatic event, the Medical Evantual to so the province of

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5 EG

State Registrar

	Registrar						77 (1170-01-0-1			neg. N		0, 2/0/1	
ın al	1. Decedent's Name		e, Last)						2.		year 3 200	. M	
er	4a. Facility Name (II	f not institution	n, give street and r	number)			4b. City, Town, o	or Location	of Death	4	c. County of De	eath	
	Ellicott	City F	Health &	Reha	b		Ellicott	City			Howard		
	5. Social Security N 213-36-89	umber	6. Sex 1 □ M 2 🔀 F	7. Age		a <i>st birthd</i> ay Yrs.	Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, Yea) 2/31/191	r) (	irthplace (State or Foreign Country) <b>England</b>	
	Usual Residence of											Table to the online	
	10a. State	10b. County				, Town or l						10d. Inside City Limits	
횼	MD	Howard	Ē		Elli	cott	City					1 ☐ Yes 2 🕱 No	
ě	10e. Street and Nur	nber					10f. Zip Code			10g. 0	Citizen of What (	Country?	
무	3000 N. H	Jidaa I	57				21043			US	Δ		
je i	11. Marital Status	uage 1	12. Was De		ver in U.S	6. 13	. Was Decedent of	Hispanic Or	igin? (Specif	fy Yes or No-	14. Race - Ar	merican Indian,	
2	1 Never Marri	ed 2□ Mar	ried 1 TYes	Forces? s 2.⊠N	lo		If Yes, specify Cub			can, etc.)	Black, Wh	nite, etc.	
<u>۾</u>	3		If Yes. 0	Give Dates:			1 ☐ Yes 2XX No	Specify	:		Specify: White		
B		15. Deceder	nt's Education	_		16a. Dec	edent's Usual Occu	pation		16b.	Kind of Busines		
<u>S</u>		ify only highe	est grade completed		,	(Giv	re kind of work done DO NOT use retire	during mos	st of working				
mo	Elementary/Seco	ndary (0-12)	College	(1-4or 5	+)	Reta	il Sales			Re	tail		
Be Completed by Funeral Director	17. Father's Name (		Last)					18. Moth	er's Name (F	First, Middle, Maid	en Surname)		
	Robert J.	Flool	/C					Eth Eth		ctoria Ma <del>May Caya</del>		.1	
은	19a. Informant's Na					19h Mai	ling Address (Stree					. Zin Code)	
	Pamela Mu	_		r			Stone Cr						
	20a. Method of Disp		Daugnice		20h. PI				Date		Location - City		
	1 ☐ Burial 2	Cremation	3 Removal from	m State	Ce	emetery, cr	oosition (Name of ematory or other pla	i					
	4 ☐ Donation						Cremation		8/13/2		anover,		
	21. Signature of Fu	ineral Sorvice	Licensee	MC	1411							mily FH, Inc.	
	( ouis	Knel									cott Ci	ty, MD 21043	
	23a. Part 1. Enter the shock, or hea	he disease, or irt failure. List	r complications that t only one cause or	t caused reach lin	the death	. Do not e	nter the mode of dy	ing, such as	s cardiac or r	respiratory arrest,		Approximate Interval Between	
	Immediate Cause (Final disease or condition												
-	resulting in death)  Due to (or as a consequence of):												
	Sequentially list conditions.												
ner	Sequentially list col if any, leading to im cause. Enter Unde Cause (Disease or	mediate	Due	to (or as	a consequ	ence of):							
ami	that initialed events	5	C										
Ä	resulting in death) l	Last	Due t	to (or as	a consequ	ence of):							
ica			d										
Med	IF FEMALE:												
Jue	23b. Was deceden		23c. If yes, o				B 🗆 Ectopic pregnan	icv			23d. Date of	,	
iż.	in the past 12 1 ☐ Yes 2 <b>∑</b>	<b>₫</b> No		egnant a	time of de		Other (specify)				Month	Day Year	
Be Completed by Physician/Medical Examiner	9 🗆 Unknown												
У.	Part II. Other signif			death bu	ıt not resu	ilting in the	underlying cause gi	iven in Part	I.	23e. Did tobacc		e to the cause of death?	
ed I	_ DEP	ICHT								1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown	
olet	DYS	SHAP	toiA							24a. Was an	24b. Were	autopsy findings available	
mo										autopsy performed	death	to completion of cause of ₁? ′es 2 □No	
ن	25. Was case refer	red to medica	al					26 Plan	e of Death /	1 ☐ Yes 2 ☐ Check only one)	40   I   Y	69 7 11NO	
	examiner? 1 ☐ Yes 2 <b>X</b>		Hospital:	☐ Inpatie	ent 2 🗆	ER/Outnat	ient 3 DOA Of	hor:		e 5 Residence	6 □ Other /S	Specify)	
Ĕ	27. Manner of Deat		28a. Da	te of Inju	ry	28b. Time	of 28c. Init			d. Describe how in		poony)	
tio	1X Natural 2 ☐ Accident	5 Pendir		onth, Da	y, Year)	Injury		orkí? ⊒Yes 2.⊑	]No		-		
fice	3 ☐ Suicide	6 ☐ Could detern	not be 28e. Pla				street, factory, office		28			Rural Route Number,	
erti	4  Homicide	detelli			:. (Specify		•			City or Town, St			
C	29a. Certifier	1 ☐ Certifvi	ng Physician: To t	the best	of my know	wledge, de	ath occurred at the	time, date a	and place, an	nd due to the cause	e(s) and manner	r as stated.	
Medical Certification: To	(Check only one)		Examiner: On the		f examinat		investigation, in my						
ž	29b. Signature and	title of certifie	er				29c. Licer	se number		29d.	Date signed (Mo	onth, Day, Year)	
	1R.F	erna	de f	XHe	vdo	X	D.	503	33	5	3 13 %	5	
	30. Name and addr		who completed ca	ause of d	eath (Item	23a) (Typ	-	SL 2		^ O = - 1	10 40	71728	
	21 Date filed (Man	- 1	nanda	51	5 N	1601	ny ma	116 6	2) (	a 10490	ie ru	2120	
te ar	31. Date filed (Mon	AUG 1	7 2009	egistra	ai s oignat	A	hores						
1						10. 19	- War						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 /Medical 4c. County of Death Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KINEY Manor 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Months Hours 1 M 2 F 215-18-417 Usual Residence of Decedent 10b. Cour Director - 01- 1920 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 🖎 📉 Director 5 (1 M)10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 216 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black. White, etc. 21 No Yes 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ♠ No Specify: Specify. If Yes, Givo Year or Dates: Blac 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Is marked other than 00 K UN KNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 00 2 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 11.335 tacke MD 00 10ston 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/15/2009 Bigwoods Cemekiy 5 ☐ Other (Specify) 22. Name and Addres of funeral. 21. Signature of Funural S Home MD 21601 assiv Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFARCTION 230 min **Physician** MYOCARDIAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as ed by the attending I IF FEMALE: yes, outcome pf pregnancy
□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HEART FAILURE 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: 5 Pending investigation Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier o completed cause of death (Item 23a) (Type, Print) peer

State Registrar 31. Date filed (Mont

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month A M 2:25 2009 DOLORES MARIE HERRIDGE August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/24/1932 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 M 2 XF 214-28-5473 76 MD Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 □Yes 2 No MDFrederick Clarksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2199 Sugarloaf Park View Lane 20871 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) county gov't bus driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William L. Carter Mary I. Gelwicks 19a. Informant's Name/Relationship (Type. Print)
Richard Herridge Sr. 19b. Mailing Address (Street and Number or Rural Route Number 10 or 200 1857 ale, Zip Code) (Husband)2199 Sugarloaf Park View Lane, Clarksburg, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rest Haven Cemetery8/15/2009Hagerstown, MD 4 Domation 5 □Other (Specify) 21. Signature of Funeral Service Licen <sup>22</sup>Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) MENINGITIS わわソら Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying traces of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

burial-transi attending physician the as nse for signed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician/Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Completed

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27

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Madical Examiner must be notified at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

		249. Was auto perí 1 □ Yes	
25. Was case referred to medical		26. Place of Death (Check onl	one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient :	DOA Other: 4 Nursing Home 5 Res	idence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?  1  Yes 2 No	how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	actory, office 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
	-1		

29a, Certifier

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 20061410 29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

TOLL HOUSE HA, FREDERICK, MD 80/ GAFFAR SYED

State Registrar 31. Date filed (Month, Day, Year)



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland /		rtment of H tificate of L			giene leg. No.	2009	27817
	Discolati		Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medic		Kathleen Shores Hall				August	-		1500 <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. (	County of Death	
1			26889 Fitzgerald Road		Princess				omerset	
-99	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	, Year)	9. Birthp Cour	lace (State or Foreign try)
	Director		217-10-2176	Yrs.			05/09/1	910	Mary	1and
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	wn or Loc	eation	_			1	0d. Inside City Limits
	sho	ō								1 □ Yes 2 No
	the A	Director	MD Somerset Prince  10e. Street and Number	ss A	nne 10f. Zip Code			10a Citiz	en of What Cour	trv?
	a or	ä			,			rog. Oniz		
	eath	era	26889 Fitzgerald Road  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	2185 Vas Decedent of His		necify Yes or No-	T 1	USA 4. Race - Americ	an Indian.
	ter d	Funeral	Armed Forces?  1 □ Never Married 2 □ Married   1 □ Yes 2 No   1 □ Yes (Give		Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puert	Rican, etc.)		Black, White,	etc.
336	al", or	Š	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2/K No	Specify:			Specify: Wh	ite
21215-0036	2 hor	Completed		a. Deced	ent's Usual Occupa	ation	lina	16b. Kir	nd of Business/Inc	
2	hin 7 9. an "n Medi	ed l	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. E	O NOT use retired,	)	Kiriy			
7	d with	ĕ		Seam	stress			<u>Clo</u>	thing	
p	al Hy l oth	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nan	,	Maiden	Surname)	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	2	Samuel Edgie Shores			Ruby Pai	ks			
a	2 sho and Is ma		19a. Informant's Name/Relationship (Type. Print)	b. Mailin	g Address (Street a	and Number or Ru	ral Route Numbe	er, City or	Town, State, Zip	Code)
	and ealth n 27 ier tr			8141	Venton R	load, Pri	ncess_Aı	nne,	MD 2185	3
ore			197 Burial 2 Cremation 3 Removal from State	ery, cren	sition (Name of natory or other place		Date		cation - City or To	
Ē	Pages ment of I ant: If its lury or o		4 □ Donation 5 □ Other (Specify) St. Pe	eter	s U.M. Ce	m. 08/1	8/2009	rio.	le, Mary	land
Baltimore,	permit. Pages Department of Important: If it any Injury or o		ignature of Funeral partial consee	22 H	.Name and Addres	s of Facility Leral Hon	ie			
ш	20 = 20	(	MOO295	11	1673_Some	rset_Ave	., Princ	cess	Anne, M	D 21853
М		1	3a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dying	g, such as cardiad	or respiratory ar	rest,		Approximate Interval Between Onset and Death
4	Physician	11	Immediate Cause (Final disease or condition	PWL.	VASCULE	Me Di	SEA> F			b work
Ρ	/Medical	-	resulting in death)  Due to (or as a consequence							5 7 6 5 5
14.	Examiner		Sequentially list conditions, b.							
	p it	Examiner	if any, leading to immediate Due to (or as a consequence Cause, Enter Uniterlying Cause, (Disease or injury)	e of):						
	ecute and -tran	cam	that initiated events resulting in death) Last  C	2 of):						
8760,	ficate be executed physician and s the burial-transit		bue to (or as a consequence	5 01).						
87	cate o	dical	d							
9 ×	feath certific attending p	Me	IF FEMALE: 23c. If yes, outcome pf pregnancy							
Box	The law requires that the death certifice has been signed by the attending tage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	3	Cities (specify)					
σ.	res that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting	in the ur	iderlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to t	ne cause of death?
Records, P.	sign d be	l by	DEMENTIA				1 🗆 1	es a	No 3 Prot	ably 4 Unknown
ŏ	w require been si should b	Completed					040 14400			finalises suellable
ğ	he law has ge 2 s	d d			<u>-</u>		24a. Was autop		prior to co death?	psy findings available mpletion of cause of
							1□ Yes	2 No	1 ☐ Yes	2 □ No
Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No. Hospital: 1 ☐ Inpatient 2 ☐ ER/C		Othe	\r'	th (Check only o			
Division or	ੜ ≑ ਲ	2		. Time of	C 3 DOA	4 LI Nursing F	ome Resid		Other (Special	y)
On	ding In. After funer	ië.	Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injun Work M 1□	k? Yes 2 ∐ No		, , , , , ,	,	
S	I or Attending after death. Director: After in by the funer	ica	3 Suicide 6 Could not be 28e. Place of injury - At home,	farm, stre					d Number or Rura	al Route Number,
2	afte afte	Certification:	4 Homicide determined building, etc. (Specify)				City or Tov	vn, State,	)	
	Hospital		29a. Certifier Certifying Physician: To the best of my knowled	ge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s)	and manner as s	tated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check only one)  2 Medical Examiner: On the basis of examination a and manner stated.	and/or in	vestigation, in my o	pinion, death occ	urred at the time,	date and	place, and due t	o the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier		29c. License			29d. Dat	e signed (Month,	Day, Year)
			1 /1/1		03	557-6		8	/12/09	
			30. Name and address of person who completes cause of death (Item 23a	) (Type,	Print)				7	
	la			D .	566 RI	VERSIDE	E DR.	SALI	SOUR O	4021801
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	4	1				(	
	Regist	CLL	A SING THE VIEW TO							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician 1036 PM Hayman 2009 Patricia Ann August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Days Hours **Funeral** Months 1 □ M 2 X F Maryland 7/30/1944 222-26-9697 65 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1X Yes 2 □ No Director DE Kent Houston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 575 Broad Street 19954 United States Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Yes Yes 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 White 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done d life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dev. Assistant - Eng. Dept. Manufacturing 12 should be filed w n and Mental Hygier r is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles S. Cooper ည <u>Jeanne (Neal) Cooper</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 other tra Dallas S. Hayman/Husband 575 Broad Street, Houston, DE Saltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 ortant: If i 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hollywood Cemetery 8/18/2009 Harrington, DE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 19952 16 vins Melvin FH, 15522 S. DuPont Hwy., Harrington, DE Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** End Stage Renal disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner patitis C Circhosh Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Jue 15 (or as a consequence of) The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Vear Day in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 H No certificate has be director, page 2 s 2 19 No 1 🗌 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 -No 2 ER/Outpatient 3 DOA 1 ☐ Yes ၉ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 - Watural Injury 2 🗌 No 1 🗌 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide

Hospital or Attending Physician: eral Director: Al filled in by the fu within 24 hours a

To the Funeral D

completely filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/12/2009 KCS 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

Heather 2. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Cornelius Heston 12:06 PM Page 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
West Virginia 8. Date of Birth (Month, Day, March 9 5. Social Security Number 7. Age (In yrs. last birthday) - 1928 **Funeral** Days Hours Months 233-42-9714 81 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show adies! Examiner must be notified at XX Yes 2 No Director Hancock MD Washington 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21750 U.S.A. 200 Maryland Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes 2√√No Specify: <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Aeronautics Painter 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Heston Lois Page Dean ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any Injury or other traum 200 Maryland Avenue, Hancock, MD 21750 Anna Jean Heston Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/24/2009 Pisgah Cemetery Morgantown, WV 4 Donation 5 Dother (Specify) Signature of Funeral Service Licensee Helsley-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part 1. Ent 4 the 1 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he miliniure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final thracrante Hemmahos **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ocardi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ougestive burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mo Month Day Year 5 Other (specify) detached 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by +enosis ACRTIC 2 No 3 Probably 4 Unknown 1 ☐ Yes cravor 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 410 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 TAccident the f 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, or Attending Physiclan: within 24 hours after death To the Funeral Director: filled in by Hospital completely

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

ancis

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wiels Q 32. Registrar's Signature

Mogerstown

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H06

251

29c. License number

EOST

ANTIETON

29d, Date signed (Month, Day, Year)

2009

Dt

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 15 11:20P™ 2009 CRAIG LEE HENNIGE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS BRADDOCK ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, DEC • 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1948 1 🔀 M 2 🗆 F WASH., D.C. 214-48-8595 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, I'm Modeal Exeminar must be notified at 1 □Yes 2\DXNo Director CHARLES MD WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3120 APPLE CREEK LANE 20603 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∐Yes 3€5√No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. ģ Specify: WHITE 3 ☐ Widowed 4☐ Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) PROMOTIONS DIRECTOR PROMOTIONS COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT VICTOR HENNIGE ပ LUCILLE MAY LUCEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r ary injury or other traur once. CHARLES ROSS HENNIGE/SON 3120 APPLE CREEK LANE WALDORF, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State AUGUST METRO. CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA 21,2009 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. re of Funeral Service Licensee Japano M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ew Min /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a co Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔊 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was an autopsy performed? Yes 250No certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this c funeral din 1 Inpatient 2 ★ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760 P.0. Division of Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the Hospital

Baltimore, Maryland 21215-0036

Medical

31. Date filed (Month, Day, Year) State

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

FNDIN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDORF MD POST PAPEL RD SHVINKUMAR

1 Rertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

determined

Registrar

			S	<b>e or Print in</b> tate of Maryla				•	_	
			For State Registrar		Cei	rtificate of	Death		g. No. 200	9,27821
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Millie W. Johr	nson				2. Date of Death Month 08 14	2009 Year	3. Time of Beath 10316am M
	Examin	er	4a. Facility Name (If not institution, give street Holy Cross	et and number)			r Location of Death er Spri:		4c. County of Dea	
aller"	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	-		thplace (State or Foreign
70	Director		223-46-8460 1 M Usual Residence of Decedent	<sup>2</sup> 73	Yrs.	Months Days	Hours Min.	10/07	/35 Ne	lson Co. Va
arvlan	show	ž	10a. State 10b. County Md Montgomer		City, Town or Lo	cation Spring				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
He M	28a-f notifie	Director	10e. Street and Number	- У	pirver	10f. Zip Code		10	g. Citizen of What Co	
h with	23a or st be	a Di	601 East Randolph	Road #1	02	209	04		USA	
r deat	er mu	Funeral	TT. Mariar Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am- Black, Whit	
5-0036	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examiner must be notified at once.	þ		1 ∐Yes 2 <b>⊠</b> No If Yes, Give Year or Dates:		1 □Yes 2 <b>\</b> □No	Specify:		Specify: B	lack
ה ה	natur	eted	15. Decedent's Education (Specify only highest grade co	on mpleted)	16a. Dece	dent's Usual Occup kind of work done	oation during most of work d)	ting	6b. Kind of Business	/Industry
Z Z Z	than the	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Dome		d)		Priva	te
and A	other orther	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Surname)	
ylar ylar	Menta arked atic ev	TO E	Willie Winston S	SR			Franc	is Fitc	h	
Mar	Ith and 17 Is m traum		19a. Informant's Name/Relationship (Type.  Sara Palmer Dauc	<sub>Print)</sub> ghter	1				City or Town, State, er Sprin	
<b>e</b> ,	Item 2		20a. Method of Disposition	20b		sition (Name of matory or other place	<del></del>		20c. Location - City or	
<b>SAITIMOS</b> Permit. Pages	ant: If		1 ☐ Burial 2 👿 Cremation 3 ☐ Remi 4 ☐ Donation 5 ☐ Other (Specify)	ovar from State			i	3/17/09	Riverd	ale,Md
Salt	Depart Import any inj once.		21. Signature of Funeral Service Licensee	2	22	Shreadadh	ortwary	Servic	e,P.A.	
			23a. Part 1. Enter the disease, or complicati	ons that caused the de						, Md 20721
PI	nysician		shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.						Approximate Interval Between Onset and Death
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uted	Insit	Examiner	rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c	- Data to for all a sone.	эционов оту.					
<b>bu</b> ,	an and rial-tra		resulting in death) Last	Due to (or as a conse	equence of):					
OO/O	attending physician and for use as the burial-transit	dical	d					· · · · · · · · · · · · · · · · · · ·		
DOX D	nding   Ise as	/Me	IF FEMALE: 23c.	If yes, outcome of preg	nancy				23d. Date of de	alivery
J. D.	he atte	Physician/Medic	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		☐ Ectopic pregnand ☐ Other (specify) _	су		Month	Day Year
r that	signed by the a		9 ☐ Unknown  Part II. Other significant conditions contrib		esulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
The law requires that the death certificate	been sign	ed by				, , ,		1 □ Ye	s 2 No 3 F	robably 4 🔀 Unknown
	n. After this certificate has been s funeral director, page 2 should	Completed	A			<del></del>		24a. Was ar	y prior to	utopsy findings available completion of cause of
<b></b> The	icate l	1 -						1 - 2	2 🔼 No 1 □ Ye	
VITAI	s certif	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	oital: 1 ☐ Inpatient 2	— ☑ ER/Outpatie	ot 3 🗆 DOA   Oth		th (Check only on	e) ence 6 □Other (Sp	aciful
10 c	ter this			28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Inju	ry at		w injury occurred	еспу)
SION	eath. Ior: Al the fu	catic	2 Accident Investigation			M   1□	]Yes 2□No			
	after d I Direct d in by	Certification: T	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or F , State)	Rural Route Number,
e Hospita	within 24 hours after death.  Yo the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier 1 Certifying Physici (Check only one)							
Toth	vithir To th	Me	29b. Signature and title of certifier	_		29c. Licens			9d. Date signed (Mor	
1	5		10000	M.D.		D64	752		August 1	4,2009
			30. Name and address of person who comp Amy Guillet Agr				t Glen	Rd Silv	er Sprin	g,Md 20910
	Sta Registr		31. Date filed (Month, Day, Year) AUG 17 2009	32. Registrar's Sig						V J J V
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DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year

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32. Registrar's Signatu

09-06566

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Sharon Susan Jordan Certificate of Death 1. For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 22, 2009 0305 hrs Sharon Sue Jordan **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 4410 Oglethorpe Street #203 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Country) 215-92-5180 Oct 10, 1962 Director M 2 X F 46 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Hyattsville MD Prince George's 28a-f show s 23a or 28a-f shove e notified at once. death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20871 TISA 4410 Oglethorpe Street, Apt 203 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? must be 1 Never Married 2 Married Yes White Specify Yes 2XX No specify: after ( 4 X Divorced If Yes Give Yan 3 Widowed the Medic 4 Examiner \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Retail Secretary MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) If item 27 is marked other 17. Father's Name (First, Middle, Last) Harry Korab Virginia Baliles Be Department of Health and Mental Important: If item 27 is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11109 Oakwood Street, Silver Spring, MD 20901 Virginia Korab /Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 XCremation 3 Removal from State Alexandria, VA Aug 23, 2009 Metropolitan Crematory Donation 5 Other Specify: 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee MAn 500 University Blvd W, Silver Spring, MD 2090 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line Death (Medical Oxycodone intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit 23a,PII,27,28a-f,perM,E g895 9/II/09 TT Physician/Medical X UNPENDED attending physician or use as the burial Box 68760, ne death certificate be e 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Live birth led by the attending detached for use as 1 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. O. 1 Yes 2 No 3 Probably 4 V Unknown ò Hepatic steatosis be o Completed 24b. Were autopsy findings available Records, 24a. Was an certificate has been autopsy prior to completion of cause of death? performed? 1 🗸 Yes No ✓ Yes 2 page 26.Place of Death (Check only one) Hospital or Attending Physician; 25. Was case referred to medical director, Division of Vital æ Residence 6 V Other: Scene Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Inpatient 2 ER/Outpatient 3 After this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27. Manner of Death Certification unk Yes 2X No 1 Natural Pending within 24 hours after death.

To the Funeral Director: Director: d in by the f Fd 8/21/09 Fd 2:48 am 28f. Location (Street and Number of Rural Route Number, City or Town, State #410 Oglethorpe St#203 Hyattsville, MD) 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide found at home determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 22, 2009 O.C.M.E. 30. Name and address of person v ho completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD. 31. Date filed (A State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Dep State Registrar	artment of Health and M <i>rtificate of Death</i>		ene 1. No. 2000	0700			
Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month August	Day Year 18, 2009	3. Time of Deaffr			
/Medica Examine	- 3	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Leonardtown	August	4c. County of Death St. Mary 's				
Funeral Director		St. Mary's Hospita1         5. Social Security Number       6. Sex       7. Age (In yrs. last birthday)         453-72-8811       1 □ M 2 ☒ F       68    Yrs.		8. Date of Birth (Month, Day,		place (State or Forentry) Texas			
D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	ocation			0d. Inside City Lim			
hours after death with the Maryland tural", or items 23a or 28a-f show of Exercitors and the profithed at	Director	Maryland St. Mary's Holly 10e. Street and Number	rwood 10f. Zip Code	10	g. Citizen of What Cour	1 □ Yes 2 🔼 ntry?			
death with ms 23a o	Funeral D	24325 Wit & Folly Farm Lane           11. Marital Status         12. Was Decedent Ever in U.S.         13.	20636 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U S A				
urs after o	ρ	Armed Forces?  1 ☑ Never Married 2 ☐ Married If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White, etc.  Specify: White				
thin 72 ho ie. ian "natur Medical	Completed	(Specify only highest grade completed) (Give life.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation be kind of work done during most of work DO NOT use retired)		6b. Kind of Business/In	ŕ			
oe filed wi tal Hygien d other th event, the	Be Cor	17. Father's Name (First, Middle, Last)		e (First, Middle, M		ξ			
nd 2 should be filed within 72 hours aft tith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, if a Madical Exami	၉	Leo H. Kotz, Jr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death and Mental Highene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exercit or mather profiled.		20a. Method of Disposition  1 ☐ Burial 2 ☎ Cremation 3 ☐ Removal from State  20b. Place of Disposeretery, cremetery, cremetery, cremation.	matory or other place)	Date 2	636 <sub>Oc. Location - City or To</sub> Charlotte F				
Departmer Pa Departmer Important: Important: any injury		21. Signature of Funeral Service Licens e	2. Name and Address of Facility Bri 22955 Hollywood Rd	nsfield :	Funeral Hor	ne, P.A.			
cate be executed bhysician and bhysician and bhysician and the prival-transit the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ung Cancer						
ath certifi attending   for use as	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver Month	very Day Year			
w requires that the descensioned by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pro	_/			
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ysic is ce dire	Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Innatient 2 ER/Outpatie	ent 3 DOA Other; 4 Nursing H	th <i>(Check only one</i> ome 5 ☐ Reside	nce 6 □Other (Spec	rify)			
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Hospital 24 hours a Funeral I	Medical Ce	29a. Certifier (Check only one)  1 Vertifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	I ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number		Od. Date signed (Month				
,			D0062705 , Print) y's Hosp; +9 P.O.Bc		08/18/2 eongration	2009			
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DHMH 17 Rev 1/2001

		•	For Stata Ragistrar	State of Ma	ryland i		artment of H <i>tificate of I</i>			giene Reg. No.	2009	27825
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ï	/Medic	al -	4a. Facility Name (If not institution, give	street and number)	111	KI	4b. City. Town, or	Location of Death	LAUGUS		County of Deat	9:05AM
¥	Examin	er	Chester River	Hospital	Con	tor	Chest	rerton	n	į	Kent	
	Funeral		Social Security Number     6. Se	x 7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	9. Birtl Co	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent		90	Yrs.			5/4/19	19		OH
	ryland how		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits 1 X Yes 2 □ No
	8a-f e	cto	MD KENT		CHEST	rerto				10a Citis	zen of What Co	
	with ti		10e. Street and Number 305 CEDAR ST.				10f. Zip Code 21620	)		rog. Citiz	USA	unity :
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.		ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	. 1	14. Race - Ame Black, White	
20	swithin 72 hours after death with the Maryland liene. Then "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1	1 ☐ Yes 2X No	Specify:	, riouri, ataly			HITE
9500-51212	2 hour	ted t	15. Decedent's Ed	ucation		6a. Dece	dent's Usual Occup	ation	vina	16b. Kir	nd of Business/	Industry
212	within 72 ene. then "nal	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	*	life.	DO NOT use retired	during most of work	ang		L & DIE	
	e filed will Hygien other th		10 17. Father's Name (First, Middle, Last)		l I	MACHI	NEST	18. Mother's Nam	ne (First, Middle,		UFACTUR Sumame)	ING
Maryland	B E D S	To Be	HARRY KING						OMI PEL			
ary			19a. Informant's Name/Relationship (7)	ype, Print)		19b. Mailir	ng Address (Street	and Number or Rur	ral Route Numbe	er, City o	r Town, State, 2	Zip Code)
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10 10	ages 1 au ont of Hea t: if item y or oths		20a. Method of Disposition  1 ABurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify			etery, crer	esition (Name of matory or other place	8/19	i i		TERTOWN	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot	I	21. Signatura 1 Funeral Service Licen	4	21.			ss of Facility HELFENBEI				
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5	Physician /Medical		disease or condition resulting in death)	a. Myoca Due to (or as a			INFAI	ZUTION				230 min
ı	Examiner		Sequentially list conditions	b. SEPS	15							7 days
	pe jisi	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a				111 0-1	n <			7 days
,	execut in and ial-trar	Examin	that initiated events resulting in death) Last	c. MULTI Due to (or as a	consequer	DEC nce ol):	MISTINS	ULCE	23			1 idays
8760,	cate be executed physician and the burial-transit	dicai	· ·	d								
9	eath certific attending p for use as f	/Mec	IF FEMALE:	23c. If yes, outcome of	of pregnanc	v					23d. Date of de	livery
Box	death e atten id for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth :	2 Fetal de	ath 3[	∃Ectopic pregnancy ∃ Other (specify) _	/			Month	Day Year
0	res that the de igned by the a be detached f	phys	9 🗆 Unknown	9□ Unknown					00 - Did.			the server of death?
	signed	δ	Part II. Other significant conditions of			-	inderlying cause giv	ren in Part I.		Yes 2		the cause of death?
CO	w require been si should t	iete	DEMENTIA	,,,,,	1				24a. Was	an	24b. Were a	utopsy findings available
Re	The law cate has page 2	Completed	Dement						autoj perfo 1 ☐ Yes	psy ormed? 2 <b>X</b> No	death?	completion of cause of
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			104	26. Place of Dea	th (Check only o	опе)		
o	Physic rthis ral dir	. To	1 Yes 25 No 27. Magner of Death	28a. Date of Injur	y 28	VOutpatier 8b. Time o	28c. Injui	y at	ome 5 ☐ Resi 28d. Describe			cify)
lon	ttending Phy death. :tor: After thii	ation	1 ANatural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Wo	rk?  Yes 2∐No				
Division of Vital Records,	or Atteriter de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc		e, larm, st	reet, lactory, office		28f. Location ( City or To			ural Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certifuwihin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	edical Ce	29a. Certifier 11 Certifying Professione) 2 Medical Exam	ysinian: To the best of iner: On the basis of and manner sta	examination	adge, deal n and/or in	h occurred at the time to execute the time to the time	me, date and plane opinion, death occu	and due to the irred at the time,	cause(s) date and	and manner a d place, and du	s stated e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	1			29c. Licens	_		29d. Dat	te signed (Mon.	th, Day, Year)
	6.		John 17/16	VU-				041587	·	8	1011	7
	rns		30. Name and address of person who is 122 peer Rd				Print) Help	en A.N.	0612, 1	MD		
1	Sta		31. Date filed (Month, Day, Year)	32. Registra	's Signatur	re A	1					
	Registr	ar	AUG I	S ZUUS P	سهما	A.	gara					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State Convergence of Manyland / Department of Fleath and Certificate of Death	a meman nye	Reg. I	2 U U No.	3 2102
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Da August 8, 20	ay Year	3. Time of Death 0754 hrs
Medical Exami	ner	Robert Harry Kociemba  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or L		August 8, 20	4c. County of Death	
		Sharrett Road & Francis Scott Key Highway Keymar	Education of Dodg		Carroll	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		8. Date of Birth(	MM/DD/YYYY) 9. Bir	thplace (State or
Director		567-74-0802 1 XM 2 F 61 Yrs. Months Days Usual Residence of Decedent	s Hours Min.	02/20/	1948	<sup>untry)</sup> Michigan
v any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
land f shov	Į	Maryland Anne Arundel Davidsonville				1 Yes 2 X No
Baltimore, MD 21215-0036  penilt. Pages I and 2 should be filed within 72 hours after death with the Maryland penilt. Pages I and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 780 St. George Road	21035	10g.	Citizen of What Cou USA	ntry?
eath wit items 2	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No			14. Race - Amer White, etc.	ican Indian, Black,
after d	by F	3 Widowed 4 v Divorced If Yes, Give Year 1970–93 1 Yes 2 x No	specify:		Specify:	White
hours matur Exam		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life			6b. Kind of Business/	Industry
36 hin 72 e. than '	ple	Elementary/Secondary (0-12) College (1-4 or 5+)  5+ Computer Security			Northrop	Grumman
5-0036 fled within 7. Hygiene. I other than	Completed	5+ Computer Secu:	18 Mother's Name (F	ialist First, Middle, Mai	den Surname)	or unmarr
121 the fill be fill be fill be fill be fill burked went, j	Be	Harry Kociemba	Linda	Cortez		
MD 21 d 2 should Ith and Me n 27 is ma	٩	19a. Informant's Name/Relationship (Type, Print)  Sara Kociemba – Daughter  19b. Mailing Address (Street 780 St. Georg				
e, M and 2 Fealth item 2 traum		20a. Method of Disposition 20b. Place of Disposition (Name of cern			Oc. Location - City or	
Baltimore, permit. Pages I ar Department of Her Impertant: If ite		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Arlington National	1 Cem. 9/	30/2009	Arlingto	n VA
mit. P mit. P partme portan ury or		4 Donation 5 Other Specify: AT LITING COIT NATIONAL 21. Signature of Funeral Service Licensee 22. Name and Address	of Facility John	n M. Tav	lor Funer	al Home, Inc
		Myelin 1. Wolfert 147 Duke of	of Glouce:	ster St,	Annapoli	s, MD 21401
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s failure. List only one cause on each line.	such as cardiac or re	espiratory arrest,	shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):				Death
		Sequentially list conditions, b.				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		d.				
760, icate be e physicial the burial	Medical	UNPENDED AMENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			22d Data of daliver	
6876 certifica ding ph	-	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnanc	су	23d. Date of deliver Month	y Day Year
O. Box 687 at the death certific d by the attending t	hysician	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown g Unknown				
O. B t the d by the	Δ.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
tal Records, P.O. cian: The law requires that it certificate has been signed by ector, page 2 should be detacl	d by			1 Yes	2 <b>V</b> No 3 Pro	bably 4 Unknown
rds v requi	Completed			24a. Was an autopsy		utopsy findings available completion of cause of
RecC The lav	mo			performe	ed? death?	
Vital F ysician: ysician: his certific director,	Be		of Death (Check on	ly one)		
of Viting Physical After this Tuneral direction	2	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA		Home 5 Re	sidence 6 Othe	r: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	(Month, Day, Year)			airplane crash	
ivisior I or Attend after death. Director:	ficat	2 V Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office but	puilding, etc. 28			ural Route Number, City
Divi Hospital or 24 hours after Funeral Dir	Serti	4 Homicide determined (Specify) Field	St	or Town, State harrett Road &	e) Francis Scott Key	Highwa, Keymar, MD
To the Hos within 24 ho To the Fun		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat (Check only)  7 Medical Examiner: On the basis of examination and/or investigation, in my opinion.				
To the within To the comple	Medical	and manner stated.				
	=	29b. Signature and title of certifier  29c. License  O.C.N			9d. Date signed <i>(Mo</i> August 9, 2009	min, ⊿ay, rear)
		Name and address of person who completed calle of death (Item 23a)				
1		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltin	imore, MD 2120	01		
St	ate	31. Date filed (Month, Day Year)	-	-		

DHMH 17 Rev 1/2001

**ORIGINAL** 

UCIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Them of Personal Properties of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0345 2009 Kucera 15 harles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arycopol (S. M.)
If Under 1 Year If Under 24 Hrs.
House Min Anne 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 89 Yrs. Months Hours 100M 20 F PΑ 76-32-41 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner , ust be notified at 1 ☐ Yes 2√√No Completed by Funeral Director MD Anne Arundel Millersville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 21108 USA 60 Linda Lane Items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1XXes 2 No 1941-1 Never Married 2 Married Saltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ™ Widowed 4 □ Divorced 1965 Year or Dates natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) US Army 4 Officer 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is markad of Peter Paul Kucera Mary Apolenak 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chuckey, TN 37641 Charlene Kucera Kaufmann daughter 261 Dunbar Rd. Health em 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö Burial 2 Cremation 3 Removal from State = 0 permit, Page Department of Important: If any injury or once. \* 4 □ Donation 5 □ Other (Specify) Arlington National Cem 10/22/2009 Arlington, VA 21. Signature of Furla al Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. al Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Klast 5 hi Priysician ~ disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Anatural 5 Pending investigation 1 🗌 Yes 2 □No death 2 Accident after death Diractor: 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho To the Fune completely f (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 39 93 SLD 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11.00mh 107 1) - we egistrar's Signatu State Registrar

	1 - State Registrar	State of Maryla		rtificate (		Reg	J. No. 9 0 11 (	2782			
ian	Decedent's Name (First, Middle, Last)     ANNABELLE LEE					2. Date of Death Month AUG • 22	Day Year	3. Time of Death  11:00 A			
ical	4a. Facility Name (If not institution, give s			4b. City. Tow	n, or Location of Dea		4c. County of Dea				
ner	15608 INDIAN H				KEEK		•	GEORGES			
	5. Social Security Number 6. Sex 218-60-0378	1	s. last birthday) 78 Yrs.		ar   If Under 24 Hrs ys Hours Min		9. Bi	rthplace (State or Foreig ountry) ) •			
	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits			
ţ	MD. PRINCE G	EORGES	F	CCOKE	EΚ			1 ☐ Yes 2 XNo			
I Director	10e. Street and Number 15608 INDIAN H	EAD HWY.		10f. Zip Co	)607		g. Citizen of What C	ountry?			
by Funeral		12. Was Decedent Ever in Armed Forces? 1		Was Decedent If Yes, specify 1 □ Yes 2X	of Hispanic Origin? ( Cuban, Mexican, Pue No <i>Specify:</i>	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE				
Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	I (Give	dent's Usual O kind of work di DO NOT use re	ne during most of wo		6b. Kind of Business	s/Industry			
mo.	Elementary/Secondary (0-12) 7th	College (1-4or 5+)	Sī	ORE C	LERK	(	GEN.MERC	HANDISE S			
Be	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)  HANNAH SUSAN KESSEL						
2	ESTON CARR		1		Zin Code)						
	19a. Informant's Name/Relationship (Ty)	•				Rural Route Number, (	•				
	TERRY LEE KIRK—  20a. Method of Disposition		Place of Dispo		f	HWY . ACC	OKEEK, P Oc. Location - City o				
	1 M Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	CCOKEEK,	MD.								
	21. Signature of Edneral Service License	M00479	F	AYMONI A PTA	FUNERAL TA, MD. 20	L SERVICI	Ε,Ρ.Α.				
	23a. Part 1. Enter the disease, or complishook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cation. That caused the decle cause on each line.  Due to (or as a conse	ath. Priot en		dying, such as cardi		st,	Approximate Interval Between Onset and Death			
Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):										
Physician/Medica	IE FEMALE:	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	tal death 3	⊒ Ectopic preg ⊒ Other <i>(speci</i> i			23d. Date of d Month	elivery Day Ye ar			
ysic	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1   Yes 2   Imo 3										
5	Cerebror	03(2(W	ي ر	Sec		-   '-					
	confestion	e hew	+ /	21/0~	8 .	24a. Was an autopsy perform	prior te	completion of cause of			
Be Completed by	25. Was case referred to medical examiner?	e hew	0		Other:	24a. Was an autopsy perform 1 □ yes 2 eath (Check only ne.	ed? prior to death? 1 □ Ye	o completion of cause of es 2 □ No			
To Be Completed by	examiner? 1 Yes 2 No F	dospital: 1 □ Inpatient 2   28a. Date of Injury (Month, Day, Year)	☐ ER/Outpatie	nt 3 □ DOA	26. Place of Do Other: 4 \sum Nursing injury at Work? 1 \sum Yes 2 \sum No	24a. Was an autopsy perform 1 □ yes 2 eath (Check only ne.	prior to death? No 1 Ve	o completion of cause of es 2 □ No			
To Be Completed by	examiner? 1   Yes 2   No   F	28a. Date of Injury	ER/Outpatie 28b. Time of Injury home, farm, st	nt 3 DOA	Other: 4 Nursing Injury at Work? 1 Yes 2 No	24a. Was an autopsy perform 1	prior to death' No 1 Ye  nce 6 Other (Sp vinjury occurred	es 2□No			
Certification: To Be Completed by	examiner?  1 Yes 2 No  27. Mann 1 Death  1 Vatural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At	ER/Outpatie  28b. Time of Injury  home, farm, strift)	nt 3 DOA  of 28c.  M reet, factory, of	Other: 4 Nursing Injury at Work? 1 Yes 2 No ice ne time, date and pla my opinion, death oc	24a. Was an autopsy perform  1  Yes 2 eath (Check only ne, 28d. Describe how  28f. Location (Stream City or Town, ace, and due to the cacurred at the time, da	prior to death.  No 1 Ye  Once 6 Other (Sp. vinjury occurred  eet and Number or State)  use(s) and manner te and place, and d	ocompletion of cause of es 2 □ No ecify)  Rural Route Number,  as stated. ue to the cause(s)			
To Be Completed by	examiner?  1 Yes 2 No  27. Mann 1 Death  1 altural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Check only 2 Medical Exami	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Spensician: To the best of my kiner: On the basis of exami	ER/Outpatie  28b. Time of Injury  home, farm, strift)	nt 3 DOA  of 28c.  M reet, factory, of	Other: 4 Nursing	24a. Was an autopsy perform  1  Yes 2 eath (Check only ne, 28d. Describe how  28f. Location (Stream City or Town, ace, and due to the cacurred at the time, da	prior to death 1 Ye  No 1 Other (Sp. vinjury occurred seet and Number or State)  use(s) and manner te and place, and d. Date signed (Mo	ocompletion of cause of es 2 □ No ecify)  Rural Route Number,  as stated. ue to the cause(s)			

DK 3

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	Flease	State of N		d / Depa		of H	ealth an		ntal Hy		_	9 27829	
Physici /Medic		1. Decedent's Name		ast) i11y							Date of Dea Month August	Day		3. Time of Death	
Examir Funeral Director		-	dia Lane	Sex 7. /		last birthday) Yrs.	Dea1	Is1	If Under 24 I	Hrs. 8	(Month, Day, Year) Co			ath irthplace (State or Foreign Country) St Virginia	
r the Maryland r 28a-f show	or	Usual Residence of 10a. State	10b. County			y, Town or Lo							10d. Inside City Limits  1 ✓ Yes 2 ☐ No		
ath with the N 23a or 28a- ust be notfit	al Director	10e. Street and Nu		Loop Road		wnsvil	10f. Zip Co	ode 032				10g. Citiz	zen of What C	Country?	
after dez or items	by Funeral	11. Marital Status	ried 2 Married	12. Was Deceder Armed Forces	t Ever in U.		Was Deceden If Yes, specify	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 □Yes 2 No Specify:			ecify Yes or No- Rican, etc.) 14. R		14. Race - An Black, Wh Specify:	Race - American Indian, Black, White, etc.	
vithin 72 hou ene. <b>than "natura</b> thedical E	Completed	(Spec	15. Decedent's cify only highest gondary (0-12)	rade completed) College (1-4o	r 5+)	16a. Decedent's Usual Occupa (Give kind of work done do life. DO NOT use retired)				e during most of working ed)				s/Industry	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, Ital Medical Exp. 2016.	To Be Co	17. Father's Name	(First, Middle, Las Brammer	<u>2</u>		LF	'IN		18. Mother's				te Hosi Surname)	pital	
I and 2 short Health and I sm 27 is ma ther trauma		19a. Informant's N Ina Cawo 20a. Method of Dis	ood/Daugl		20h E	9956	ng Address (S  India  osition (Name	Lan			land,	MD 2	21821	or Town, State	
artment of bortant: If ite		1 <b>X</b> Burial 2 4 □ Donation	•		e c	emetery, cre 11cres	t Ceme 1	r place ter	y 8/	17/2				Maryland	
de la como de la como		asa. Part1. Enter t shock, or hea Immediate Cause disease or condition	the disease, or co art failure. List on (Final on	mplications that caus y one cause on each	M002 ed the death line.	95 <u>1</u> h. Do not en		ome	rset A	ve.,			Anne,	MD 21853 Approximate Interval Between Onset and Death	
eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	resulting in death) Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	onditions, nmediate erlying r injury s	b	as a conseques as a conseques as a conseques as a conseques as a conseques as a conseques as a conseques as a conseques as a consequence as a	uence of):	)								
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w requires that the d s been signed by the should be detached	<u>ک</u>	Part II. Other signi	ificant conditions	contributing to death	but not res	ulting in the u	inderlying caus	se give	en in Part I.		23e. Did t		1	to the cause of death?  Probably 4 Unknown	
n: The law re icate has been r, page 2 sho	Completed								_	_	1 □ Yes	psy prmed2 No	24b. Were prior t death 1 🗆 Y		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To Be	25. Was case referexaminer? 1  Yes  RZ Manner of Deal  Natural 2  Accident	No	28a. Date of li (Month, I		ER/Outpatie 28b. Time o Injury	nt 3 DOA of 28c	Othe	4 □ Nursii	ng Home	> /	dence 6	Other (S <sub>i</sub> ) Occurred	ecify)	
ital or Atter rs after dea al Director led in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of	njury - At ho etc. <i>(Specil</i>	ome, farm, st	reet, factory, of	ffice		28	f, Location ( City or To			Rural Route Number,	
thin 24 hour thin 24 hour the Funer	Medical	29a. Certifier (Check only one) 29b. Signature and	∠2   Medical Ex	Physician: To the be aminer: On the basis and manner	of examina		nvestigation, in	my o				date and	I place, and d		
<b>5</b> ₩ ₩ 00		Pe	25	o completed cause	death (Iter	n 23a) (Type.	D	2	627	3		Lou. Dat	8/14/	OF	
Sta		31. Date filed (Mon	occall Y oth, Day, Year)	Ocos A	Strar's Signa	one	90 BOX	17	733	Sa	Vish	M	1 2	1801	
Registr	rar		AUG 17	2009	مهما	p. 1	gare								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 9:00 AM **Physician** AUG 2009 Lewis Robert Rov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 14311 Old Lake Drive, SW Cumberland If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Pay, Jul 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1945 Days 1 **X**M 2 □ F Months MD 213-44-1918 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h Count 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ant; If item 27 is marked other than "natural", or items 12a retilied any or other traumatic event, no. Sedien Ervier in all the profiled any or other traumatic event, no. Allegany MD Cumberland 1 ☐ Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14311 Old Lake Drive, SW 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 PYes 2 □ No If Yes, Give Year or Dates: Vietna Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Saltimore, Maryland 21215-0036 Specify: Specify: Completed by Vietnam white 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sergeant Major National Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M. Everhart Archie W. Lewis ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14707 McMullen Hwy. Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Bric Lewis son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 ☐ Removal from State Rocky Gap Veteran's Cemetery 8/26/2009 MD Flintstone 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications of at called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate C use (Final disease or or addition resulting in d. u.)

Due to for as a consequence of the called the mode of dying, such as cardiac or respiratory arrest, line. Approximate Interval Between Onset and Death BARS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Undeadorn's that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 ANO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Nesidence 6 □ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1230 M **Physician** Louise Lucas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner rumberlana Hilegan wmHS-Braddock Campus If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Dec 3, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1924 1 □ M 2 □ **x**F Months Days Hours 220-16-7090 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Extrainer must be notified at MD Allegany Cumberland 1 □ Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12612 McMullen Highway 21502 USA Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ ☐No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 Specify Specify: Completed by white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Memorial Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer R. Brown Mary Ann Adams မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12612 McMullen Hwy. Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) husband 12612 McMullen Hwy. Philip Lucas Jr. permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🕇 Burial 2 □ Cremation 3 □ Removal from State 8/28/2009 Sunset Memorial Park Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens-22. Name and Address of Facility al Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party. Enter the disease, or comilica ons hat a sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, of heart failure List only on- caus, or ear line.

Imm diate C use (Final disease or or indition resulting in lear)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiseuse of It just that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): nding physician are as the burial Box 68760, Physician: The law requires that the death certificate be Physician/Medical cate has been signed by the attending p page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) P.O. ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 1 □ Yes 2 200 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No patient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifig

Emmanuel

-Boamon 32. Registrar's Signature

31. Date filed (Month, Pay Year) of and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

SH

29c. License number

Dang 515

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 15:05 PM 16 Wallace Manning August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Union Hospital of Cecil County E1kton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Hours Days 1 XM 2 □ F Virginia 20,1948 Director 60 225-60-6730 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. \*\* 10d, Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2XXV Director Maryland E1kton Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 46 Shiloh Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 NYes 2 NoUS Army If Yes, Give Year or Dates: 1968-70 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ▼No Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivonia Smith Linwood Manning, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Shiloh Drive, Elkton, Maryland Jean H. Manning / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery 20c. Location - City or Town, State August 24, 20a. Method of Disposition 2009 Bear, Delaware 22. Name and Address of Facility 21. Signatur of uperal Service Live Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mensun **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed be hours after death. Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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within 24 To the F

Division or Vital Records, P.O. Box 68760

242

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

4 Homicide

29b. Signature and title of certifier

29a, Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

. IDG BOW STREE 32. Registrar's Signature

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Avaust 16, 2009

ELKTON, MARZHLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 10, 2009 **Physician** 1622 P BRUCE LEROY MAXWELL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHESTERTOWN KENT CHESTER RIVER HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 10/5/1941 Director 212-40-9204 67 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinat must be notified at 1 ☐ Yes 2 ☐ No Director MD KENT CHESTERTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 209 OLD BRIDGE RD. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 □ No If Yes, Give Year or Dates: N/A 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married Married altimore, Maryland 21215-0036 1 □ Yes 2 ŪNo Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WATERMAN SEAFOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE B. MAXWELL MARY LEROY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a CATHERINE MAXWELL/WIFE 209 OLD BRIDGE RD. CHESTERTOWN, MD 21620 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition o <u>.</u> Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY 8/15/09 CENTREVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 408 S. LIBERTY ST. CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or es a consequence of): **Examiner** Diseas DYON Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \bigcap \) Nursing Home 5 \( \bigcap \) Residence 6 \( \bigcap \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of

10

State Registrar 31. Date filed (Month, Day Year) 32. Register's Signature AUG 13 200 August 1.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Bal	permit. Departr Importa any Inju		21. Signature of Funeral Ser	Signature of Funeral Service Licensee  Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20											ıa. MD 2090		
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Mardian Evan in an interest once.	To B	Samuel L.	McMickle	, Sr.				Ma	arjorie l	Ree Ca	annon		
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Σ	and 2		Carolyn McMickle/	Wife		4702	Cede	211 1	PLace To	emple Hi	11, M	D 2074	8	
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			31. Date filed (Month, Day, Year)  AUC 1 8 2009		istrar's Signa	4 2m	عملا	رد	CKIN	Jean Jord	1	177		
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Cora Lucinda Mackall 3:00p<sup>M</sup> 2009 August 8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hyattsville Prince Georges Saint Thomas Moore Nursing Ctr. If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 101 <sub>Yrs</sub> Davs Hours 1 □ M 2**X** F Months Washington DC 577-24-5730 Director Feb. 6, 1908 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Landover M D Prince Georges 1X Yes 2 □ No Director 10f. Zip Code **20785** 10g. Citizen of What Country? 10e. Street and Number United States 6506 Maureen Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, e filed within 72 hours after on Hygiene.

In Hygiene... 1 X Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ∐Yes 2¥21No Specify: þ Specify A merican 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) General Accountant Office Elementary/Secondary (0-12) College (1-4or 5+) Accountant Clerk 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be þ if Health and Mental Daniel Mackall Cora Davis ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6506 Maureen Ct., Landover, MD 20785 Sandra E. Hawkins / Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ott
once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/14/2009 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Avenue, NW, Washington DC 20012 Cendra Moupson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -terroscientic Canaliovascular Disease **Physician** 4 acres disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) the o 9 ☐ Unknown 9 Unknown signed by the ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by ment Kidney Discare Staper 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? reviewsion 24a. Was an has Physician; The page Dementia certificate 2 No 1 □Yes 1 ☐Yes 2 ☐No 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the ft investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I within 2 29b. Signature and title of certifier AVGUST 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 QUEENSBURY Rd Hyuttville (U) 2078 DEVORE MA 31. Date filed (Month, Day, AUG 1 Registrar's Signa State Registrar

			For State	State of Maryland / [			ntal Hygiene	2009	27837
			Registrar		Certificate of E		Reg. No. Date of Death		3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)	00 11:			Month \_ Day	2 20/20	1505 PM
	/Medic	al	Daisey Ma	e Mathis	4b. City, Town, or	Location of Death	000	County of Deeth	70001
	Examin	er	4a. Facility Name (If not insutution, give s	I M 1. I	40. City, 10mil, of		1	1	11'00
			5. Social Security Number 6. Sex	7. Age (In yrs. lest bir	thday) If Under 1 Year		Date of Birth	9 Birthol	ece (State or Foreign
	Funeral Director		2/1-20-7/269 10		Yrs. Months Days	Hours Min.	(Month, Dey, Year)	114 Mac	
			Usual Residence of Decedent						
	rylan how		10a. State 10b. County	10c. City, Tow	n or Location			10	od. Inside City Limits 1 ☐ Yes 2 No
	Ba-f-	cto	DE Sussen	k bric	geville				/ /
	ith th or 24	Dire	10e. Street and Number	11 ^	10f. Zip Code	• 0 - :-	10g. Citi	zen of What Count	ry?
	s 23a	rai	KTI BOX3	overdales (10	55 161 1°	1933	Joseph Voseph	ed State	S OF (INCIO
	item Item	Funeral Director	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?     □ Yes 2 NO	13. Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto Ric		Black, White, e	
S	ars at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: B	ack
5	72 hours after death with the Maryland natural, or items 23a or 28a-f ehow dical Exam her must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupa (Give kind of work done do	ition	16b. Ki	nd of Business/Ind	ustry
<u>'</u>	within 7 iene. Then r	npie	Elementary/Şecondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	)	5	11	
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	ould be filed with Mental Hygiene arked other the atic event, itself	Be	17. Father's Name (First, Middle, Last)	1 1		18. Mother's Name (F	Irst, Middle, Malden	Surname)	V
20	should nd Men marke umarlic	2	Charles K	oberts	. Mailing Address (Street a	M(IS	YVIQO	Town State Zin	Code
	0 a = 2		19a. Informant's Name/Relationship (Typ	1) 0 1 1 Lt 5	. Maining Address (Street a	A A	Rall	2200 1	(D) 21212
ת ב	1 and Health tem 27		20a. Method of Disposition	20b. Place o	f Disposition (Name of	Date	20c. Lo	cation - City or To	wn, Steta
2	ages int of t: If It		1 ☐ Burial 2 【VCremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ry, crematory or other place	e) cesq	2,299	maria	DE
	permit. Pag Department Important: I eny Injury c		21. Signature of Funeral Service License	en Cremo	22. Name and Address	s of Facility De F	1250 614	arn's -1	Vacis
Ö	Depa Impo eny i		1 Donate	X / 111	DO BOYT	Balder	2110 DE	199	33
0	J. M. 120		23a. Part1. Ener the disease, or complic	atking at caused the death. Do	not enter the mode of dying	g, such as ca + c or re	espiratory arrest,		Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final	A C C . ( )					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence	of):				
	Examiner		Sequentially list conditions, b.	CVA					
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
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000	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	dical	d						
XOO	certif nding use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	_			23d. Date of delive	ry
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ວ	2 2	pie					24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
		Completed					performed? 1 ☐ Yes 2 🔀 No	death?	2 🗆 No
	ysician: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?		lou.	26. Place of Death (C	The state of the s		
	× .º 0	2	TES ZENO	ospital:		er: 4 ☐ Nursing Home			0
	aling F	lo	27. Manner of Death 1 SNatural 5 ☐ Pending		Time of 28c. Injury Injury Work	vat ⟨? Yes 2 □ No	f. Describe how inju	ry occurred	
VISION	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa			. Location (Street ar	nd Number or Rura	il Route Number,
2	after Direct In by	Certification:	4 Homicide determined	building, etc. (Specify)	ann, stroot, ractory, cinco		City or Town, State	9)	
	Hospital or Attanding Physician: 44 hours atter death. Funeral Director: Alfer this certificately filled in by the funeral director,			ician: To the best of my knowledge					ated.
	n 24 I n 24 I he Fu	edical	(Check only 2 Medical Examin	er: On the basis of examination ar and manner stated.	nd/or investigation, in my op	oinion, death occurred	at the time, date and	d place, and due to	ine cause(s)
	To the Hospital or Attanding Phyminin 24 hours attendeath.  To the Funeral Director: After th completely filled in by the funeral	Σ	29b. Signature and title of certifier		29c. License	number	29d. Da	te signed (Month,	Dey, Year)
	0.00		Sa. M.D	β	257	952	08/	13/09	
	JYN.		30. Name and address of person who con	npleted cause of death (Item 23a)	(Type, Print)	alis bear	MD2	1804	
	U		Bubiled Das. 10 ( 31. Date filed (Month, Day, Year)	32. Benistrar's Signature	T 20401	- way	,		
	Sta Registr		AUG 17 20	mpleted cause of death (Item 23a) 32. Registrar's Signature	park				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2009 5:05 a<sup>M</sup> 8 13 Howard W. Melvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 MM 2 F Director 215-01-4551 92 11-12-1916 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director Y☐Yes 2☐No Berlin MD Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11421 Manklin Creek Road, A6 Funeral 21811 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No Army
If Yes, Give
Year or Date≰: 942-45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married - 13 - 2009 aナ Maryland 21215-0036 1 ∐Yes 2 ∐XVo Specify Specify White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MD National Bank Financing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Showellhouse ဂ္ Howard Melvin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Hahn Melvin/Wife 11421 Manklin Creek Rd, A-6, Berlin, MD 21811 Iffmore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Direct Crematory 8/14/2009 Dover, DE 4 Donation 5 Dother (Specify) 21. Sign re Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St Bennie Smith Funeral Home Salisbury, MD 2180 Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart Failure **Physician** Congestive disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Aortic Steriosis Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to (or as a consequence of) burial-transi and Due to (or as a consequence of) Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe Yes 2 Mitral stenus: s completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Howard alsi-ol 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar Juson Szymal. DO

31. Date filed (Month, Day, Year)

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Healthway

Berlin, MD

9733

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Registrar	State of Mary		rtificate of			giene 200	9 2/83
	Physici		1. Decedent's Name (First, Middle, La.  Marieantonia M.		.a. Sal	ly Maiba	uer	2. Date of Dea Month August	Day Year	3. Time of Death 7:50 AM M
	/Medic Examir		4a. Facility Name (If not institution, given Homewood at Crum			4b. City, Town, o	or Location of Death	1	4c. County of Dea	ath Ck
	Funeral Director		5. Social Security Number 140–10–8422	,	yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Day April	23, 1911 Ve	rthplace (State or Foreign ountry)
	Maryland a-f show	tor	10a. State 10b. County Maryland Frederic		c. City, Town or Lo Frederic					10d. Inside City Limits Y☐Yes 2☐No
	th with the 23a or 28a	<b>Funeral Director</b>	10e. Street and Number 7407 Willow Re	oad	-	10f. Zip Code 2170.	2		10g. Citizen of What C	ountry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evention I must be notified at ances.	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		
21215-0036	ithin 72 houns na. han "natura e Medical E	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire rical Wo	during most of wor d)	king	16b. Kind of Business  Insurar	ŕ
	should be filed withind Mental Hygiena smarked other thar umatic event, the	To Be Co	10 17. Father's Name (First, Middle, Last) Ralph Schinel		CIE	ilcai wo.	18. Mother's Nan	ne (First, Middle, nine Sant	Maiden Surname)	ice
, Maryland	and 2 shou ealth and M n 27 Is mar ner traumat	٦	19a. Informant's Name/Relationship ( Susan Smith, Gran	**	1				ck, MD 2170	
Baltimore,	permit. Pages 1 Department of H Important: If iten any Injury or oth		20a. Method of Disposition  1 ☐ Burial 2 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	Smithsbu	rg Crema	tory Aug.			ourg, MD
Bal	permii Depar Impor any Ir	,	21. Signature of Funeral Service Line		0255   K	Name and Addre eeney an 06 East	d Basford Church St	l PA Fund	eral Home erick, MD 2	
	Physician /Medical Examiner	0	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line.  a.  Due to (or as a cor	64105	er the mode of dyi	11	or respiratory ar		Approximate Interval Between Onset and Death
,09		al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor						
O. Box 687	The law requires that the death certificate be executed are has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → 6 9 □ Unknown	23c. If yes, outcome of pr 1  Live birth 2  4  Pregnant at time 9  Unknown	Fetal death 3 [	□ Ectopic pregnan □ Other <i>(specify)</i> _	су		23d. Date of do	alivery Day Year
Records, P.	w requires that is been signed by should be detail	þ	Part II. Other significant conditions o	ontributing to death but no	t resulting in the ur	nderlying cause giv	ven in Part I.		obacco use contribute	to the cause of death?  Probably 4 Unknown
_	ician: The law certificate has b ector, page 2 sh	Completed						24a. Was a autop perfor 1 🗆 Yes	sy prior to meg? death?	autopsy findings available completion of cause of s 2 □No
·Vital	Physician: r this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No	Hospital:	2 ER/Outpatier	ot 3 🗆 DOA Oth	or:	th (Check only or	<i>ne)</i> lence 6	ecity)
	fte		27. Manner of Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Yea	28b. Time of	f 28c. Inju Wo		1	now injury occurred	cony
Division	Hospital or Attendii 24 hours after death. Funeral Director: A tely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (S	pecify)			City or Tow		
	To the Hospital or , within 24 hours after To the Funeral Dire completely filled in the	Medical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deatl mination and/or in	h occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the arred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	Nithi Normy	Ž	29b. Signature and title of certifier	100 -		29c. Licens	se number		29d. Date signed (Mor	nth, Day, Year)

3 DK State

31. Date filed (Month, Day, Year)

AUG 3 1

30. Name and address of part on who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III, M.D., 300 West Ninth Street, Frederick, MD 21701

32. Registrar's Signature

29c. License number D 16428

August 24,

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 3:55 13, Edith M. Norris 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Yrs. Director 215-76-2700 December 3, 1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminat ment Legiculied at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ∐Yes 21∏ No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42400 St. John's Road by Funeral 20636 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 🖾 No Specify: 3 ☑ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aurthur Gatton ပ Rosie Cecelia Stone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Norris / Son 42400 St. John's Road Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State August 19, 2009 Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 21. Signature of Funeral Service 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ▼No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 201No 2 **Z** No 1 ☐ Yes\_ 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNaturai 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25365 Pt. Lookout Road William D. Boyd, II M.D. Leonardtown, MD 20650 31. Date filed (Month 18 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009<sup>ear</sup> August 12 Day 6:40 A M Bernard NOCKS 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Rockville Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 19, 1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours New York 1√2 M 2 □ F 94 147-09-3073 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 ☑ No Bethesda Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20814 5450 Whitley Park Terrace #911 Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: white 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bureau of Printing Elementary/Secondary (0-12) College (1-4or 5+) and Engraving Plate Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mollie Sufrin Kalman Nocks ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 5450 Whitley Park Terrace #911, Bethesda, MD 20814 Paula Nocks, Wife 20c. Location - City or Town, State 08/14/09 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA King David Memorial Garden 21. Signatur of Furral revice L Torchinsky Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as a consequence of): Cardiomyopathy (ischemic Due to (or as a consequence ot): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aortic Stenosis Exami Due to (or as a consequence of) Chronic Kidney Disease IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) l □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 第 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending 1X Natural

Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

e Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 To the Hosp within 24 ho To the Fune

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

ir than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after ann of Health and Mental Hygiene. Interest I them 27 is marked other than "natural", or lite any or other traumatic event, It is Market Examinany or other traumatic event, Its Market Examina

permit. Pages 1 and: Department of Health Important: If Item 27 any Injury or other tr once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Directo

Completed by

the Maryland

with 1

death

Physician/Medical þ Completed Be မ Certification: 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1241

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

August 12, 2009

29d. Date signed (Month, Day, Year)

Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 31. Date filed (Month, Day, Year)

AUG 1 7 2009

State Registrar 2. Registrar's Signature

29c. License number

163740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** June Ann Offenbacher 2:55 A<sup>M</sup> 2009 13, August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 465 Roundup Road Lusby Calvert f Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 🛛 F 216-60-0887 55 June 23, 1954 Washington, DC Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 1 ☐ Yes 2X No Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 465 Round Up Road 20657 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: Specify: White þ 3 ☐ Widowed 4 💆 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event, the Merical Injury or other traumatic event injury or other event injury or other eve Retail Manager Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Frederick Offenbacher Margaret Agnes Becker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Windsor/daughter 7020 Evergreen Drive Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8-16-2009 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Crematory Charlotte Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00817 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service L 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) lyear pancreat /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the. as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) the Ö 9 Unknown ed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by sign No 3 Probably 4 Unknown 1 🗌 Yes none 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ∐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 □ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar M. Naomi Horiba, M.D. 22 South Green St. Baltimore, MD 21201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 9:45 a 18, O'Neal August Donald Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Great Mills 45895 Dogwood Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours Min. Months Days 1**X** M 2 □ F 06/23/1943 Maryland 66 Director 213-40-4825 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Great Mills St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any injury or other traumatic event, the Modical Examiner must be n 20634 USA 45895 Dogwood Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No If Yes, Give Year or Dates: Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Administrator 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be O'Neal Margaret Nally ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vicki Jean O'Neal/Wife 45895 Dogwood Lane, Great Mills, MD 20634 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Boonsboro Cemetery 08/22/2009 Boonsboro, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 dward N. Brinstield, M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Yeer 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: in by the 6 □ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane, Leonardtown, MD 20650 Jennifer Schmidt 32 Registrar's Signatu 31. Date filed (Month, Day, Year) AUG 20 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** Glenda Olinde 4:50 08 13-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Coastal Hospice at the Lake Salisbur Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F 437-68-0587 65 Director 01/31/1944 Louisiana Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evanther must be notified at 1 Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1129 Riverside Drive 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. white ≥ If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate agent . Pages 1 and 2 should be file trrent of Health and Mental H tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Henderson Flora Kilmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Riverside Dr., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Alford Olinde/spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parsons Cemetery 8/17/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Keller 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MRTASTATIC RRNAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence on Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No. 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has the autopsy performed? Yes 2.⊿No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence of Other (Specifit OS PICA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the cause (s) and manner as stated.

Destination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29b. Signature and title of certifier

State Registrar BOX

Fegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WAGRY

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31. Date filed (Month, Day, Year) AUG 14

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			For State	State	of Marylar		artment ertificate				giene Reg. No. '	0000	0701.5	
			Registrar  1. Decedent's Name (First, Middle, L	ast)				0. 200		2. Date of Dea	_		3. Time of Death	
	Physici /Medic		Miriam L. Ohre	,		,				August	Day 14	2009	7:50 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, g				1	wn, or Locati			4c. (	County of Death		
			Laurelwood Nur				If Under 1	Elkton	der 24 Hrs.	9. Date of Birt		Cecil	place (State or Foreign	
	Funeral Director		215-32-9644	Sex 1 □ M 2 K F	7. Age (in yrs	92 Yrs.		Days Hou	rs Min.	8. Date of Birt (Month, Da) Oct. 2,	Year) 191	Coui	nnsylvania	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation			-		1	0d. Inside City Limits	
	f sho	ō											1 X Yes 2 □ No	
	28a-	%	Maryland   Cecil			Elkton	10f. Zip C	ode			10g. Citiz	zen of What Cour	ntry?	
	with the the		100 Laurel Dr.					21921				USA		
	ns 2:	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U	J.S. 13.	Was Deceder		Origin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Americ		
36	be filed within 72 hours after death with the Maryland that Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Matrial Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed F 1 ☐Yes If Yes, G Year or I	2 🐴 No ≩ive		lfYes,specify 1 □Yes 2 <b>X</b>			Rican, etc.)	Specify: White			
2-0	72 hou 'natura dical E	eted	15. Decedent's l (Specify only highest g		")	16a. Dece (Give	dent's Usual ( kind of work of DO NOT use	Occupation done during i	most of worki	ng	16b. Kind of Business/Industry			
21215-0036	hould be filed within id Mental Hygiene. marked other than 'matic event, me was matic event.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		ore Cl				Gene	ral Mer	chandise	
b	il Hyg other	Be C	17. Father's Name (First, Middle, Las	t)				18. M	lother's Name	(First, Middle,	Maiden S	Surname)		
Maryland	12 should be fi th and Mental I 7 is marked ot traumatic evel	To E	Leon Delmont C	arlton				Mary Buob						
ary	should be summarked by summarke	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta									Town, State, Zij	Code)		
	and 2 salth 27 i er tra		Barbara Lum/Daughter 79 North St. Augustine Rd., Chesapea											
nore	ages 1 and 2 should bent of Health and Ment nt: If item 27 is marked y or other traumatic e		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Contents)		n State	Place of Dispo cemetery, cree ethel	natory or other	er place)	8/20/	2009		cation - City or To	own, State	
Baltimore,	permit. Pages 1 Department of F Important: If ite any Injury or ot		21. Signature of Funeral Service Lice		1>		2. Name and	Address of Fa	acility Funera	1 Home,	P.A			
	20200		23a. Part   Enter the disease, or co	mulications that	caused the dea	ath Do not en						ity, MD	21915 Approximate	
			shock, or heart failure. List onl	y one gauge on	each line.					or respiratory at	1631,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)		ebro V		ne f	ccid	on t		-		unknown	
1	Examiner			Due to	o (or as a conse	quence of):								
	-	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  c											
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury											
oʻ	an an rial-tr		resulting in death) Last	Due to	o (or as a conse	quence of):								
8760,	icate be executed physician and s the burial-transit	dical		d										
9	ng ph	Med	IF FEMALE:											
O. Box	Physician: The law requires that the death certificate be executed ribis certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 🗆 Live	utcome of pregre birth 2 ☐ Fet gnant at time of known	tal death 3[	☐ Ectopic pred ☐ Other (spec				2	23d. Date of deliv Month	ery Day Year	
<u>Р</u> О	that the dended by the a		Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying cau	se given in P	art I.	23e. Did to	obacco u	se contribute to t	the cause of death?	
g	uires sign d be	d by								1 🗆 1	es 2	□ No 3 □ Pro	bably 4 Unknown	
COL	w requires to s been signal should be	Completed								24a, Was	an	24b. Were auto	opsy findings available	
Be	The lay	Ĕ								autor perfo	sy rmed?	prior to co death?	mpletion of cause of	
ta	ician: The certificate ector, pag	ပိ	25. Was case referred to medical									1 ☐ Yes	2 ∐ No	
>	Physician: this certific	<b>m</b>	examiner?	Hospital:	Inpatient 2	☐ EB/Outpatie	nt 3 🗆 DOA					3 □ Other <i>(Sp</i> ec	f(v)	
ō	eral c	<u>ان</u>	27. Manner of Death	28a. Date	e of Injury	28b. Time o		, Injury at		28d. Describe I			-97	
<u>o</u>	Attending or death. ector: After by the fune	Injury   Work?												
Division of Vital Records,	or Atte after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not determine	be d 28e. Plac build	ce of Injury - At I ding, etc. (Spec	home, farm, str cify)	reet, factory, o	office		28f. Location (3 City or Tov	Street and vn, State)	d Number or Rur )	al Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the aminer: On the and ma	ne best of my kr basis of examir inner stated.	nowledge, deat nation and/or in	th occurred at nvestigation, in	the time, da	te and place, , death occur	and due to the red at the time,	cause(s) date and	and manner as I place, and due	stated. to the cause(s)	
	To the Ho within 24 h To the Fu completely	Me	29b. Signature and title of certifler  29b. Signature and title of certifler  Ccccc  30. Name and address of person wh  S.S. SAC+1DE  31. Date filed (Month, Day, Year)  AUG 17	s mis			29c. l	Dood	ber 23322		29d. Dat	8 . /4. 8		
	6		30. Name and address of person wh	o completed cau	use of death (Ite	em 23a) (Type,	Print)	St.	Elki	in MI	219	721	•	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature	0 -7	/		,				
	Registr	-	AUG 17	2009	Beneva	B. 19	park							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 52/PM Zoso **Physician** 15 26 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 0 TIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Months Days Hours Min. 1 □ M 2X F 59 MD 10-9-1949 Director 216-56-0990 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Somerset. Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a 11412 Bratten Avenue 21853 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify Black Baltimore, Maryland 21215-0036 1 ∐Yes 2**X** No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salvation Army 9th Receptionist permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event. In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Alonzo Wallace, Sr. <u>Alice Jones</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Yvonne Collins/Daughter PO Box 363, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other phace) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Direct Cremation, | 8-17-2009Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith 917 W. Isabella St. Service Lice Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONARI **Physician** /Medical Due to (or as a consequence of): Examiner 7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physlclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and physician are s the burial-t Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Records, Division of Vital

> State Registrar

29a, Certifier

(Check only

29b. Signature and title of certifier

OSEPH

Medical

31. Date filed (Month, Day,

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

0

\*\*Eertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Pate signed (Month, Day, Year)

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Records,
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Year Physician 9:08 2009 RACHEL Roland TUGUST /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner MEDICAL CENTER P ATA IVISTA 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
August 23, 1923 Maryland Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2X F 85 579-20-3012 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evandral and 1 ☐ Yes 2 ☑ No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29911 Woodland Circle 20659 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√ No Specify Completed by Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Pyles Edith Peaper ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Roland/son 11933 Montgomery Lane Waldorf, MD 20602 permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8-21-2009 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Brinsfield-Echols Crematory 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, Maryland 21. Signature of Funeral Service Lin nsee M00817 22. Brinsfield-Echols Funeral Home, P.O. Box 128 Charlotte Hall, MD 20622 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** oulec disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown this certificate has been si al director, page 2 should 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. n 24 hours after death.

■ Funeral Director: A

bletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the within 7 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year) 29c. License number D0056949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KAMAKSHI BAIG MD 6426 CRAIN 6620 CRAIN HWY #102 LAPLATAMD 20646 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health <i>ertificate of Deat</i>			n n n n	37516
			Registrar  1. Decedent's Name (First, Middle, Last)	sitincate of beat		Reg. i	6. 3 5 3	3. Time of Death
	Physicia /Medic		Aiden Andrew Russell			gust 16	Day 2009 Year	6:05pM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locatio			4c. County of Death	•
444			St. Mary's Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda		ardtown der 24 Hrs.   8. D	ate of Birth	St. Mar	
ľ	Funeral Director		1 M 2 F	Months Days Hours	rs Min. (i	Date of Birth Month, Day, Yes Just 16,20		place (State or Foreign ntry) [aryland
	w w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			1	0d. Inside City Limits
	Maryla a-f sho	tor	Maryland St. Mary's	Cleme	ents			1 ☐ Yes 2 X No
	/ith the	Director	10e. Street and Number  24111 Coles Adventure Lane	10f. Zip Code 20624		10g.	Citizen of What Cour	
	hs 23a	Funeral		3. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify )	Yes or No-	14. Race - Americ	
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational be multiple and if all or other traumatic event.	by	Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexic 1 ☐ Yes 2 A No Speci		n, etc.)	Black, White,	_
2-0	72 hou nature	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during m	nost of working	16b	. Kind of Business/Ind	dustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)					
197	il Hygi other rent, t	Be C	17. Father's Name (First, Middle, Last)	18. Ma	other's Name <i>(Fir</i> :	st, Middle, Maid	den Surname)	
/lar	wild be i Mental arked o atic eve	TO B	Andrew Thomas Russell	No	ancy Mar	ie Nels	on	
/ar	2 should be and Mental is marked or raumatic ev			illing Address (Street and Nur. 11 Coles Adver				
re,	s 1 and f Health item 27 other to		20a. Method of Disposition 20b. Place of Dis	position (Name of	Date	20c	Location - City or To	
Baltimore, Maryland	Pages ment of I		4 Donation 5 Other (Specify) Queen of F	rematory or other place) Peace Cemetery	August 20 2009	),	Helen, Maryl	and
Ball	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any Injury or other tra once.		21. Signature of Funeral Service Licensee	22. Name and Address of Fac			diner Funera ardtown, MD	al Home, P.A. 20650
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause a ach line.			piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	ĺ		PRZMTUN	-277			Onset and Beati
	Examiner		Due to (or as a consequence of):					
	ed sit	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury					
Ć,	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last  C					
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	± 0.6	Med	IF FEMALE:					
O. Box	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	Pery Day Year
s, P.	signed by the property of the deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Pa	art I.	23e. Did tobaco	co use contribute to t	he cause of death?
ord	w require been si should b					1 ☐ Yes	2⊠No 3□ Prol	bably 4 Unknown
Vital Records,	The ate h	Completed				24a. Was an autopsy performed 1 □ Yes 2 🗷	prior to co death?	opsy findings available ompletion of cause of 2  □No
Vita Vita	ician: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	Cabonin	lace of Death (Ch			
	Phys	٦.	1 ☐ Yes 2 ဩ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time			5 Residence	e 6 Other (Special	fy)
0	nding I th. :: After e funer	ation	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation				ija. y oodanaa	
Division of	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitely filled in by the funeral director,	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office		ocation (Street City or Town, St	t and Number or Rura tate)	al Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.					
	To th withir To th comp	Me	29b. Signature and title of Certifier	29c. License numbe	er	29d.	Date signed (Month,	Day, Year)
			/ ///////	D0043	2819		72 16	. 05
			30. Name and address of person who completed cause of death (Item 23a) (Typ Namdhi Davis, MD 25500 Point Loo		ard+a-	Mn o	1650	
	Sta	te	31. Date filed (Month Day, Year) 2009 32 Registrar's Signature	Lad !	arut OWII,	rii) Z(	0650	
	Registr	ar	AUGUEL D. A	100 See				

Aiden Andrew Russell

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Рм August 19, 2009 6:18 Robert Henry Remmel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F Director 295-22-2048 October 17,1929 Ohio Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be redflind at 1 ☐ Yes 2x No Director Maryland St. Mary's Hollywood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 43144 Joy Lane 20636 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. White Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0il Company Tankerman 1.2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Agnes O'Donnell Edward Henry Remmell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau Hollywood, MD 20636 43144 Joy Lane Joyce Lorraine Remmel / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State August 28, 4 ☐ Donation 5 ☐ Other (Specify) Joy Chapel Cemetery 2009 Hollywood, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final weed **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to innuciate cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed 2 No 1 □Yes 2 □N 1 🗆 Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28b Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Holly wood md rederle hah Assoc. 1 2009 31. Date filed (Month, Day, State AUG 21 Registrar

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State of Maryland / Department of Health and Mental Hygiene

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500	100	100	dent.	ALMOTTO:	- 8	$\vee$	9	1

		1- For State Registrar Certificate of Death	h	Reg. I	No.			
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da August 19, 2	ay Year	3. Time of Death 0427 hrs		
		Doctors Community Hospital Lanha	Town, or Location of Death am	or Location of Death  4c. County of Death  Prince George's  ear If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign W 55H)				
Funeral Director		577 02 1189 1_M 2\sqrt 39 Yrs Month						
Maryland 28a-f show any	7	Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 X Yes 2 No		
h the Maryla  3a or 28a-f otified at or	I Director	10e. Street and Number 10f. Zip 3223 SCARLET OAK TERRACE	20715	10g.	Citizen of What Coun	try?		
ter death wit ", or items 2	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specif	ent of Hispanic Origin? (Sp fy Cuban, Mexican, Puerto		14. Race - Americ White, etc.  SpecifyBLAC			
2 hour	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	red)	DERAL GO	ndustry			
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than antic event, the Medica		12 PURCHASI  17. Father's Name (First, Middle, Last)  GREGORY BAGLEY	ASING AGENT FEDERAL GOV:  18.Mother's Name (First, Middle, Maiden Surname)  DOROTHY JONES			VERNMENT		
2121 hould be fil nd Mental F is marked ttic event,	To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address	(Street and Number or R	ural Route Number	r, City or Town, State,	` '		
nore, MD 2 ages 1 and 2 shoul nt of Health and N t: If item 27 is n other traumatic	-	20a. Method of Disposition 20b. Place of Disposition (Nan	RLET OAK T		BOWIE MD  Oc. Location - City or 1			
	-	1 X Burial 2 Cremation 3 Removal from State GLENWOOD CE 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		8/09	WASHINGTO	ON, D.C.		
		WATSO	N F. H. 34		ST.NW W			
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		respiratory arrest,	SHOCK, OF Healt	Between Onset and Death		
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):						
execuran and an and and and and	Medical B	XUNPENDED AMENDED 23a,P11,2/,permE, §	g895 9/8/09 :	IT				
	sician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (Spec	3 Ectopic pregnar		23d. Date of delivery Month Da	ay Year		
hat the ded by the letached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	•		cco use contribute to the			
ords, P	sted to	Acute pyelonephritis; Fatty liver; Chron	nic	1 Yes 2		opsy findings available		
tal Recor	Completed	Pancreatitis				ompletion of cause of		
Vital Rec ysician: The this certificate director, page	To Be	examiner?	26.Place of Death (Check of Other) OOA Other Nursing		sidence 6 Other:			
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safer death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted.	tion:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 2	28c. Injury at Work?	28d. Describe how	injury occurred			
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certificate that the death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, (Specify)	, office building, etc.	28f. Location (Stree or Town, State		al Route Number, City		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
6	Σ	29b. Signature and title of certifier 29c	O.C.M.E.	1	ed. Date signed <i>(Mon</i> Nugust 19, 2009	th, Day, Year)		
en		30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltir	more MD 21201					
Sta	te	31. Date filed Manth Day York Street, Baltin Street						
Registr	ar	HOUR O LAND CONTRACT OF MANAGE						

		,	1 - For State Registrar	State of Marylar	•		nt of Health are			jiene leg. No. 2	009	27851
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici: /Medic		Doris Koberts						88	10	2009	10:56 PM
1	Examin	er	7								nty of Death	5
	- Francisco		5. Social Security Number 6. Se		last birthday)		SOURY MO		3. Date of Birth	1		lace (State or Foreign
	Funeral Director			DM 2XF 81	Yrs.	Months	Days Hours	Min.	(Month, Day	( Year)		vland
	g ,		Usual Residence of Decedent	10- 0	h. Taua aut							0d. Inside City Limits
	aryla • hov	č	10a. State 10b. County		ty, Town or Lo							1 ☐ Yes 2 ☑ No
	28a-1	ect	MD Wicom	ico S	alisbu:	ry 10f. Zij	Code			10a. Citizen	of What Cour	ntry?
	3a or	Funeral Director	1949 Cedar Way				21801			υ.	S.A.	,
	death	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Dece	dent of Hispanic Ori city Cuban, Mexican	igin? (Spec	ify Yes or No-		Race - Americ	
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1  Yes			ioari, bio./		cifv:	
ğ	hours tural',	ed by	3   Widowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	16a Doop	dont's Hou					Business/Inc	hite
Ċ	in 72 in "na" n	Completed	(Specify only highest gra-	de completed)	(Give	kind of wo	al Occupation ork done during mos se retired)	st of working	9	160. Kind o	i Business/inc	uustry
212	d with giene.	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Minis	ster				Ch	urch	
פ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f ehow aumatic event, Ira Medical Examinar must be notified at	ВеС	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (	(First, Middle,	Maiden Sun	name)	
<u>ya</u>	should to ind Ment ind Ment ind Ment ind Ment ind Ment ind Ment ind Ment ind Ment	To	Ralph Wilson					Anna				
Maryland 21215-0036	12 sh h and 7 le m rraum		19a. Informant's Name/Relationship (7			-	s (Street and Number			•		
	ss 1 and 2 should b of Health and Ment item 27 le marked r other traumatice		John Mitchell  20a. Method of Disposition	(grandson)	Place of Dispo	sition (Na	k Forest	Drive			SC on - City or To	29407 own, State
on o	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	cemetery, cre	-	1	.~ 1.6	2000			
Baltimore,	permit. Page Department of Important: If any njury or and.		21. Signature of Funeral Service Licen		rsons	2. Name a	nd Address of Facili	ity	, 2009	Sarrs	bury, I	Maryland
ñ	8 9 E 8		Pinen Short	- Dewell		Short 13 Ea	Funeral st Grove	Home Stree	t Delm	nar, D	E 199	40
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea	th. Do not en	ter the mo	de of dying, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between
; I	Physician		Immediate Cause (Final disease or condition	a. Unnary Due to (or as a conse	tract	infect	15					Onset and Death
<i>3</i> ;	/Medical Examiner		resulting in death)									
		er	Sequentially list conditions, if any, leading to immediate	b. C = duff		ſ						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Find stage	e des-	enta						
o '	e exec en an rial-tr	Еха	resulting in death) Last	Due to (or as a conse								
8760	cate be executed physicien and the burial-transit	dicai		d								
×	death certific e ettending p od for use as	/Mec	IF FEMALE:	23c. If yes, outcome of pregn	ancy						D	
Box	eath c	Physician/Me	in the past 12 months?	1 Live birth 2 Fet	al death 3[	☐Ectopic p☐Other (s				230.	Date of delive Month	Day Year
o.	t the d	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown			,,					
ທ໌ ລັ	law requires that the de as been signed by the e 2 should be detached f	by P	Part II. Other significant conditions co	ontributing to death but not re-	sulting in the u	inderlying	cause given in Part I	l.	23e. Did to	bacco use c	ontribute to the	ne cause of death?
Vital Records,	w require been si should t	ted							1 🗆 Y	es 2□No	3 Prob	pably 4 Unknown
Ö	law r nas be s 2 sh	Completed							24a. Was a	sv	prior to co	psy findings available mpletion of cause of
E	: The lav	Co							perfor 1 Yes	med? 2 No	death? 1 🗌 Yes	2[] No
	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					(Check only or			
	a ± ₹	. To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o		28c. Injury at Work?		e 5 ☐ Resid 3d. Describe h			y)
5	otending I deeth. ctor: After y the funer	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	м	Work? 1 ☐ Yes 2 ☐	No				
DIVISION		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · Al h building, etc. (Speci	ome, farm, st	reet, factor	y, office	28	Bf. Location (S City or Tow	treet and Nu	ımber or Rura	al Route Number,
	ittal o irs eft rai Di	Cer										
	To the Hospital or, within 24 hours efter OYO the Funeral Dire completely filled in the Funeral Director of the Funeral Direct	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of my kn iner: On the basis of examin	owledge, deat ation and/or in	h occurred vestigation	at the time, date and, in my opinion, dea	nd place, ar ath occurred	nd due to the o	ause(s) and date and plac	manner as s ce, and due to	tated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29	c. License number		2	29d. Date sig	gned (Month,	Day, Year)
		a la	) Sk.	10 Arral			06822	2		08	113/09.	
	M		30. Name and address of person who d	completed cause of death (Ite	m 23a) (Type,	Print)				- 0	101	
	1		RAZA MPZAL	1415 S. D	ivision	. 57	Ste B,	Salis	bury	MD	2180	4
\$ .	Sta Registr	_	31. Date filed (Month, Pay, Year) AUG 1 4 200	3. Registrar's Sign	abure de	N			·			

		For State Registrar	State of Me	ai yiai iu		tificate of	Death	-	Reg. No.	2009	27852
Dhuaisia		1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
Physicia /Medic		Ge	orge Morton	Reyno	lds,	Jr.		August	24	2009	
Examine		4a. Facility Name (If not Institution		_ ,	r Location of Death	1	4c.	County of Dea	th		
		Union Hospital				E1kto				Cecil	
Funeral Director		5. Social Security Number 212-70-0465	6. Sex 7. Ag 1 <b>X</b> M 2 □ F 51	e (In yrs. Ias L	t birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEPT 2	ıy, Year)	Co	thplace (State or Foreign ountry) elaware
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Loc	ation					10d. Inside City Limits
/faryl	ò		<b>4</b> 1	E11	kton						1 □Yes 2 💢 No
the 28a	rec	Maryland   Cec	11	ETI	CLOII_	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
3a ol	a D	345 Appleton R	load			2192	1		Uı	nited S	tates
deat sms	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V		lispanic Origin? (S an, Mexican, Puert	pecify Yes or No		14. Race - Ame Black, Whit	erican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Erwnir er must be rediffed at once.	by Funeral Director	1 ☐ Never Married 2 🙀 Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 🔀 If Yes, Give 🗙	No		□Yes 2MNo		o riioari, etc.)		Specify:	nite
72 ho	Completed	15. Decedent (Specify only highes				lent's Usual Occup	nation during most of work	kina	16b. Kir	nd of Business	/Industry
ithin ne.	npl m	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. E	OO NOT use retired	d)	9	_		
led w lygie her tl	Be	17. Father's Name (First, Middle,	1 2		E1	ectricia	n 18. Mother's Nan	oo (Eiret Middle		<u>Electri</u>	cal
intal Hed of ed of ed of ed of even			•					•		ourname)	
hould nd Me mark matic	은	George Morton  19a. Informant's Name/Relationsl			10h Mailin	a Address (Street	and Number or Ru	Guibes		r Town State	Zin Code)
id 2 s Ith ar 27 is trau		Patricia Reyno					Road, El			1921	<b>Lip</b> (3000)
f Hea		20a. Method of Disposition	Ids/ Wile	20b. Plac		sition (Name of natory or other place		Date		cation - City or	Town, State
t. Pages rtment o rtant: If i		1 ☐ Burial 2 🕅 Cremation 4 ☐ Donation 5 ☐ Other (Si	pecify)		Ferri	s & Co., L	nc. 2009	st 25,			ester, PA
permi Depar Impol any ir		21. Signature of Funeral Service	( کر	*.	<sup>22</sup>	Name and Addre	ess of Facility ne for Fur ockton St	nerals,	P.A.		
		23a. Part . Enter the disease, or	L. Riom	d the death						n, MD	21921 Approximate
		shoo, or heart failure. List Immediate Cause (Final	only one cause on each li	ne.		•	ng, saon as sarata	or respiratory e			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as	AL F		K12.					
Examiner			b. ENC			7 14					
	Jer	Sequentially list conditions,	b. Due to (or se	a nonesque	les of)	1 (1)					
rificate be executed ng physician and as the burial-transit	Examiner	Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. SEPS	S1 S							
e exe ian ar irial-ti	Ĕ	resulting in death) Last	Due to (or as	a consequer	nce of):						
ate b hysic the bu	edical		d		-						
ertific ling p e as t	100	IF FEMALE:	1								
To the Hospital or Attending Physician: The law requires that the death entwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use it	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1  Live birth 4  Pregnant a	2 Fetal de	eath 3	Ectopic pregnand Other (specify) _	су		2	23d. Date of de Month	elivery Day Year
d by	Phy	9 Unknown  Part II. Other significant condition	one contributing to death t	out not reculti	ng in the un	adortvina cause aix	en in Part I	23e Did	tobaccou	ise contribute t	o the cause of death?
quires tl en signe uld be d	ed by	Tartii. Ottier significant condition	Als contributing to death b	out not resum	ng in the ti	idenying cause giv	remini arti.				Probably 4 Unknown
aw re	Completed							24a. Was			utopsy findings available
The I	mo;								projed? 2 No	death?	
slan: artifica ctor, p	Bec	25. Was case referred to medical examiner?					26. Place of Dea				
hysic his ce I dire	2	1 ☐ Yes 2 No	Hospital:	ent 2□EF	R/Outpatien	t 3□DOA Oth	ner: 4 \(\sum \) Nursing H	lome 5□ Res	idence (	6 □Other (Spe	ecify)
ding P h. After t funera	Certification:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investig		ury 28 ay, Year) 28	8b. Time of Injury	28c. Inju Wor	ryat 'k? ]Yes 2 □No	28d. Describe	how injur	y occurred	
Atten deat ctor:	fica	3 Suicide 6 Could r	not be 28e. Place of Inj	jury - At hom	e, farm, stre	eet, factory, office					Tural Route Number,
tal or s after al Dire	Certi	4 ☐ Homicide determ	building, et	tc. (Specify)				City or To	wn, State	)	
e Hospit 1 24 hour e Funera letely fills	Medical (		ng Physician: To the best Examiner: On the basis of and manner st	of examinatio							
To th withir To th comp	Me	29b. Signature and title of certifier	r			29c. Licens				te signed (Mon	
		P.V.Nego	N MD				065733			08/25/3	9
		30. Name and address of person	Δ. Δ	death (Item 2	3a) (Type, I	Print) Italy 51	meet, EL	KNN, 1			-
Stat Registra		31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur	e B	Barred					
. rogiotit		noug	- LUUJ LERE	1	80 Six	Colon Services					

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2009	2	18	5
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cquiyn Denise			cate of Death		g. No.				
Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Deat Month	Day Year	3. Time of Death 0402 hrs			
ledical Exami		Jacqulyn Denise Roof  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	August 22 Death	4c. County of Death				
		Washington County Hospital	Hagerstown		Washington				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under  Months Days Hours	Ation	7, 1987 Co	hplace (State or Foreign Intry) Lorado			
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow				10d. Inside City Limits			
	ō		hsburg			1 Yes 2 X No			
y MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and mental Hydromen Hydromen Hydromen Hydromen Hydromen Hydromen Hydromen Tis marked other than "natural", or items 23a or 28a-f sho traunnatic event, the Medical Examiner must be notified at once.	I Director	100. Street and Number 12004 Bayer Drive	10f. Zip Code 21.783		10g. Citizen of What Country? U • S • A •				
eath wit items 2 ust be r	Funeral	11. Marital Status  1 X Never Married 2 Married 12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? ( Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ameri White, etc.	can Indian, Black,			
after d al", or	by Fu	3 Widowed 4 Divorced of Dates:	1 Yes 2 X No specify:		Specify: Whi				
hours "natur	ᄝ	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation (Give kindering most of working life, DO NOT upper properties)</li> </ul>		16b. Kind of Business/	ndustry			
036 ithin 72 ne. r than '	Complete		Waitress		Resturau	mt			
21215-0036 Nuld be filed within 7 Mental Hygiene. marked other than	ادہ ا	17. Father's Name (First, Middle, Last) Donald M. Roof		Name (First, Middle, I					
212 ould be 1 Mentz 5 mark ic even	To B	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Numb	per or Rural Route Nur	nber, City or Town, State	e, Zip Code)			
MD nd 2 sho alth and m 27 is sumsti	·		12004 Bayer Dr. Sm	ithsburg,	MD 21783 120c. Location - City or	Town State			
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiest I hoperant! If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examines		1 V Rurial 2 Cremation 3 Removal from State crem	natory or other place) Isburg Cemetery	8-25-2009	Smithsburg	g, Maryland			
Baltii permit Departm Importa Injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 1331 Eastern B	Douglas A. Lvd. North	Fiery Fune: Hagerstown	ral Home MD 21742			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	· · · · · · · · · · · · · · · · · · ·			Approximate Interval Between Onset and			
/Medical *xaminer			ication complicated	l by drown:	ing	Death			
		Sequentially list conditions,  b							
	niner	if any, leading to immediate cause. Enter Underlying Cause							
ed nsit	Examine	events resulting in death) Last Due to (or as a consequence of):							
760, Teate be executed sphysician and the burial - transit	Medical	X <sub>UNPENDED</sub> d	Ba-f,permE, G896 10	)/9/09 TT					
760, icate be physic the burite buri		IF FEMALE: 23c. If yes, outcome of pregnan 23b. Was decedent pregnant in the			23d. Date of deliver				
Box 687  The death certification of the attending properties of the attending properties as the second of the seco	Physician/	23b. Was decedent pregnant in the past 12 months?  1							
O. B. t the de by the		Part II. Other significant conditions contributing to death but not result	Iting in the underlying cause given in Pa	rt I. 23e. Did i	tobacco use contribute to	the cause of death?			
ires that signed!	d by				es 2 No 3 Pro				
cords law requi has been 2 should	Completed			24a. Was		utopsy findings available completion of cause of			
tal Rec rian: The la certificate h	Com			1 🗸 Yes		es 2 No			
Vital I hysician: this certifi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ EF	26.Place of Death R/Outpatient 3 DOA Other	Nursing Home 5	Residence 6 Other	er:			
1 of V ling Phy After th funeral of	n: To	27. Manner of Death  28a. Date of Injury (Month, Day, Year)	Bb. Time of Injury 28c. Injury at Work		how injury occurred				
Sion vttendi death. ctor:	atio	Natural 5 Pending Investigation Fd 8/22/09 F	d 3:34 am 1 Yes 2 X		(Street and Number of F	ural Route Number, City			
Divisitat or Attra all Direct	Certification:	3 Suicide 6 X Could not be determined (Specify) Found in	e, farm, street, factory, office building, et a bathroom	or Town, Smiths	State) 3() E. He	nrietta St			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and pla	ice, and due to the cau	use(s) and manner as sta	ited. he cause(s)			
To To	Me	and manner stated, 29b. Signature and title of certifier	29c. License number	0011	29d. Date signed (M	onth, Day, Year)			
		Throdore Mr King JAM A	O.C.M.E.	OCME	August 22, 200	9 			
		30. Name and address of person who completed cause of death (Itém 23 Theodore M. King, Jr., MD. Assistant Medical Exa		Itimore, MD 2120	)1				
	tate	31. Date filed (Mogth, Day, Year) 32. Registrar's Signature							
Regis	માસ	AUG 3 I 2009 Ceneva A.	Paris and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 3:49 a M Bobby Conn Sellers August 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1 🕱 M 2 🗆 F 08/19/1941 216-40-5552 67 Vi<u>rgi</u>nia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 □ Yes 2√CXNo Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20659 29026 Autumnwood Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🖼 No Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Computer Systems Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dallas Sellers Bertie Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29026 Autumnwood Dr., Mechanicsville, MD 20659 Brenda M. Sellers/Wife 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Charles Memorial Grd. 08/20/2009 Leonardtown, MD 4 □ Donation 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ertiogenic disease or condition resulting in death) Due to (or as a consequence of): metabolic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Conterointes resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? irnosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Action Examiner mant be notified at

and Mental Hygie is marked other

Health a Pages 1 a. nent of Hea.

Department o Important: If i any Injury or

permit.

3altimore,

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Division Hospital or Attending Funeral Director

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Completed

Be

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filed within 72 hours after death with the Maryland

Physician/Medical Examiner Be Completed by

funeral director, Certification: To

certificate has

after death

within 24 hours a

To the Funeral D

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 🗌 Unknown

> 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🗖 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

29c. License number

D 0060473

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary's Hospital P.O. Box 527 Leonardtown Registrar's Signatur 31. Date filed (Month, Day, Year)

State Registrar

Medical

			1- For Amend Items 25,27,28 a per	Depa Cer	tificate of De	odband Meath	lental Hygi	iene g. No. 🤈 🗎 🗇	0 0705
	Physici		1. Decedent's Name (First, Middle, Last)  Mary K. Stover				2. Date of Death Month 08		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Union Hospital		4b. City, Town, or Loc	cation of Death	4c. County of D	eath	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖫 F 90	oirthday) Yrs.	If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08 30	Year) 9.	Birthplace (State or Foreign Country) ennsylvania
	f show	or	Usual Residence of Decedent		eation				10d. Inside City Limits 1X Yes 2 □ No
	death with the Maryland ims 23a or 28a-f show	Funeral Director	10e. Street and Number 271 Mike Drive		10f. Zip Code 219	21	10	ng. Citizen of What	Country?
Daltimore, Maryland Z1Z15-U036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evan Instrust by publication.	by Funera	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give  Year or Dates:		I Vas Decedent of Hispa Yes, specify Cuban, N □Yes 2 <b>X</b> No <i>S</i>	anic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, Inite, etc. White	
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give F	ent's Usual Occupation kind of work done during O NOT use retired)	ng most of worki	ing 1		d of Business/Industry	
and 2	ld be filed w lental Hygie ked other ti Ic event, th	Be	12   17. Father's Name (First, Middle, Last) Walter B. Kindon		- 1	. Mother's Name	(First, Middle, M	,	-uring
lary	nd 2 should lith and Me 27 Is mark r traumation	2	19a. Informant's Name/Relationship (Type. Print)		g Address (Street and ike Drive,	Number or Rura	al Route Number,	City or Town, Stat	e, Zip Code)
MOTE, N Pages 1 and nent of Health int: If item 27 iry or other ti	Pages 1 ar nent of Hea int: If item : iry or other		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Possition 5 Other (Cossiti)	of Dispos ery, crem delp	ition (Name of atory or other place)		Date 2	20c. Location - City	
Банттог	permit. Page Department of Important: If any injury of once.		21. Signature of Fuheral Service Licensee  CCD0442	22.	es Name and Address of bhart Fune	f Facility	3401		phia Pike
	hysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	- DE	er the mode of dying, so	an are	or respiratory arre	est,	Approximate Interval Between Onset and Death
E	Examiner	ner	Sequentially list conditions if any, leading to independ the control before the control b	W068	dial				
,0070	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the cons	of):	17000	CERTIFICATION	A PROVED BY MEI	DICAL EXAMINER	
מס אסם	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending pheompletely filled in by the funeral director, page 2 should be detached for use as the	sician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat		Ectopic pregnancy Other (specify)	0,22		23d. Date of Month	delivery Day Year
٥, ٦.	es mar me o igned by the be detached	by Physi	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given in	n Part I.	23e. Did tob	acco use contribut	e to the cause of death?
ecords,	has been s e 2 should	Completed	left hip wast & sho	Mala	en Asset	hore	24a. Was an	24b. Were	Probably 4 Unknown a autopsy findings available to completion of cause of
VII	anig Frivsician: The n	æ	25. Was case referred to medical examiner?		Other		(Check only one	1 D	Yes 2 □ No
	th. : After this ! funeral di	tion: To	1   27. Manner of Death   28a. Date of Injury   28b.   453.   28b.   2	Time of Injury	28c. Injury at Work?		me 5 Resider 28d. Describe how Subject	_ '_'	Specify)
	s after dea al Director ed in by the	Certification:	3  Suicide 6 Could not be determined 28e. Place of Injury - At home, f building, etc. (Specify)				28f Location (Str.	eet and Number of State) 271 M	r Rural Route Number, like Drive,
1	in 24 hour the Funera ppletely fills	edical	29a. Certifier (Check only one)  1 ★ Certifying Physician: To the best of my knowledge 2 ★ Medical Examiner: On the basis of examination a and manner stated.	je, death and/or inv	occurred at the time, oestigation, in my opinion	date and place,	and due to the ca	use(s) and manne	r as stated. due to the cause(s)
	To To con	M	29b. Signature and title of certifier  Raselsland, M. S.			mber 7922	29	Od. Date signed (M	onth, Day, Year) 5 / 2009
			30. Name and address of person who completed cause of death (Item 23a)  RAJAL SHAH > 106 Bow  31. Date filed (Month, Day, Year)  AUG 18 2009  32. Registrar's Signature	Stol	Pet, Elk	ton,	MD 21	921	
	Sta Registra		AUG 18 2009 Sender B. A	bar					

			For State Registrar	State of Ma	aryland			of Health and of Death	i Mentai H	ygiene Reg. No		07056	
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of D		4, 2009	3. Time of Death 3.5:05 A M	
1	/Medic	al	Jean Louise Shi 4a. Facility Name (If not institution, give				4h City Tow	n, or Location of De	Augu		County of Deatl		
	Examin	er	12428 Palermo Dri					r Spring			ontgomer		
	Funeral Director		5. Social Security Number 6. So 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9x 7. Age □ M 2 <b>X</b> F	e (In yrs. la	st birthday) 6 Yrs.	If Under 1 You Months Da	ear If Under 24 H ays Hours Mi		irth Day, Year)	9. Birti 20 Cal	hplace (State or Foreign untry) ifornia	
	put w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Loc	cation					10d. Inside City Limits	
	Maryla f sho	ţō	MD Montgome	257		er Spr			,			1 ☐ Yes 2 🛣 No	
	h the h	Director	10e. Street and Number	ı y	DITAG	er opr	10f. Zip Co	de		10g. Ci	itizen of What Co	untry?	
	23a c		12428 Palermo Dri				2090			USA			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. If the marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "fical Eventha" or until be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 💆 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ▼ If Yes, Give Year or Dates:			Vas Decedent fYes, spedfy I∐Yes 2∭X	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Ame Black, White Specify: Wh		
21215-0036	2 hou natura ical E	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	dent's Usual O	ccupation	vorkina	16b. k	Kind of Business/	Industry	
121	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			one during most of w etired)	rorking	Edu	cation		
d 21	illed w Hygiel ther th		17. Father's Name (First, Middle, Last)	5+		Teach	er	18. Mother's N	ame (First, Midd				
Maryland	2 should be filed within 7 h and Mental Hygiene. 'is marked other than "raumatic event, the Mo	To Be	Hyman Lawrence Gi	nsburg					Elizabe				
ary	shou and M s mar	-	19a. Informant's Name/Relationship (7	Type. Print)		19b. Mailin	ng Address (St	reet and Number or	Rural Route Num	ber, City	or Town, State, 2	Zip Code)	
	1 and 2 Health a em 27 is		John A. Shickel/h	usband				mo Drive S					
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition   1										
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Going Home Cremation S  Beverly L. Heckrotte,													
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode o	f dying, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death 2 months	
-	Physician /Modical		Immediate Cause (Final disease or condition resulting in death)	Liver Fa								2 months	
	/Medical resulting in death)  Due to (or as a consequence of):  Metastatic Breast (						Cancer					3 years	
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as								7	
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Right Br			er					23 years	
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189	tificate ng phy as the	fedical		.u									
O. Box	Physician: The law requires that the death certificate has been signed by the attending I this certificate has been signed by the attending Irail director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2   Fetal	death 3□	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year		
σ.	that the		Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the ur	nderlying caus	e given in Part I.	23e. Die	d tobacco	use contribute to	the cause of death?	
rds	w requires to been signer should be a	ed by							_ 1[	Yes 2	2 □ No 3 □ Pi	robably 4 🗌 Unknown	
of Vital Records,	: The law re cate has be page 2 sho	Completed			· · · · ·				24a. Wa au pe	topsy rformed?	prior to death?	utopsy findings available completion of cause of	
ta	ician: Th certificate ector, pag		25. Was case referred to medical	-				26. Place of F	1 ☐ Yes	24LIN	lo 1 □Yes	: 2 □ No	
ίV	ysician: nis certific director,	To Be	examiner? 1 ∐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	R/Outpatier	nt 3 🗆 DOA				6 ☐Other (Spe	ecify)	
o uoi	nding Ph ath. r: After th e funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of inju (Month, Da	y, Year)	28b. Time of Injury	98c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how inju	ury occurred		
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubuilding, etc	ury - At hor c. (Specify	me, farm, str	treet, factory, office 28f. Location (Street and Number or F City or Town, State)				and Number or Ri te)	ural Route Number,	
	To the Hospital within 24 hours and the Funeral completely filled	Medical (	29a. Certifier (Check only one)  1 ★ Certifying Ph 2 ★ Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examinati	vledge, deatl ion and/or in	h occurred at t vestigation, in	he time, date and pl my opinion, death o	ace, and due to t ccurred at the tim	he cause( le, date ar	(s) and manner a nd place, and due	s stated. e to the cause(s)	
_	To ti Vithi Comj												
	12)		alcee					D6564	5	A	ugust 1	5,2009	
	E.G.		30. Name and address of person who rebecca Kaltman,					#506 Ba+b	ടപ്പോ സ്ഥ	200	17		
	Sta	te	31. Date filed (Month Apar Year) 7	32. Régistra	ar's Signati	ure /	barre	TOO DELLE	esua, MD	208	17		
	Registr		AUG 17 2	UUS Dener	un	D. A	acke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 14, 2009 au **Physician** 7:45 SOBEL ам Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery S. Leisure World Blvd #508 Silver Spring 2901 (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Date of Birth 9. Birthplace (State or Foreign Country)

January 14,1921 Czechoslovakia 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age Funeral 1 □ M 2 🛣 F 130-09-2645 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. If a Martinal Exercise. 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location Silver Spring Maryland Montgomery 1 ☐ Yes 2 ☐**X**No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 South Leisure World Blvd. #508 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ∐ Yes 2 📜 No Specify: \$ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simma Goldberger Fishel Greenstein ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Poistorstown. Md. 21136 19a. Informant's Name/Relationship (Type. Print) 2210 Crestnoll Rd., Reisterstown, Md. Paul Sobel / son Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 16, 2009 01ney, Md Judean Mem. Gardens 22. Name and Address of Facility Torchinsky Hebrew Funeral Home of Funeral Service Licenses 21. Signature 254 Carroll St., N.W., Washington, D.C. 20012 sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that c shock, or heart failure. List only one cause on Immediate Cause (Final Physician Malignant Lymphoma (Non-Hodgkins) 12 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of]: Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) ed by the detached 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 【 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has b page 2 s autopsy performed death? certificate 1 □Yes 2 X No 2 🗆 No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ YNo 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) August 14, 2009 29b. Signature and tile of certifier 29c. License number D29675 5 empleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 20817 6420 Rockledge Dr., #4100, Bethesda, Md. Ralph Boccia, MD 3 Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG 17** and Registrar

autopsy perform 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 💘 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Natural

Accident

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5 ☐ Pending investigation

6 ☐ Could not be

D 46345

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

certificate

After

Director:

Be

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Certification:

Medical

3 ☐ Suicide

29a. Certifier

To the Hospital or Attending Physiclan:

death.

within 24 hours a

			State of Maryland / De	partment of ertificate of			iene eg. No. 2 A A Q	27050	
	Physici	an	Decedent's Name (First, Middle, Last)		<del></del> ·	2. Date of Death	h	3. Time of Death 5:58p M	
1	/Medic Examin		Michael Joseph Stanton, Sr.  4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, Anna	or Location of Death		4c. County of Deat		
	Funeral Director		5. Social Security Number	Months Days		8. Date of Birth (Month, Day, Sept. ]	9. Birt Year) 1951 Wa	hplace (State or Foreign unity) Shington, DC	
5-0036	e Maryland 8a-f show	ector	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or  Maryland  Queen Anne	Grasonvil	lle			10d. Inside City Limits 1 □ Yes 2 □ No	
	h with th	<b>Funeral Director</b>	10e. Street and Number  12 Fairway Island	10f. Zip Code 21638		1	0g. Citizen of What Co USA	untry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, It is Mulical Experiment must be notified at once.	d by Funer	1 □ Never Married 2 Married 1 □ Yes 2 Mo If Yes, Give Year or Dates:	3. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Specify:		14. Race - Ame Black, White Specify: <b>Whi</b>	e, etc. Lte	
1215-	within 72 hiene. iene. than "nath	Completed by	(Specify only highest grade completed) (G.	cedent's Usual Occu ive kind of work done e. DO NOT use retire Urologi	during most of wor ed)	king	16b. Kind of Business/ Health		
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Baltimore, Maryland 21215-0036	and 2 shousalth and Nath and N						City or Town, State, 2		
imore	Pages 1 ament of He ant; If iten ury or oth		1 Rurial 2 Cremation 3 Removal from State	sposition (Name of rematory or other pla litan Crer		uqust 17	20c. Location - City or Alexandria,		
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vision	Attending r death. sctor; Afte by the fune	Certification:	27. Manner of Death  1  Natural 2  Accident 3  Suicide 4  Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)  28b. Time (Month, Day, Year)  28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Time Injury 28b. Place of Injury 28b. Time Injury 28b. Place of Injury 28b. Time Injury 28b. Place of Injury 28b. Time Inju	y Wo M 1 E	ork? ⊒Yes 2 □ No	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	lo the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/o and manner stated.						
	Vithin To the comply	Me	29b. Signature and title of contiller	29c. Licen	se number	D36797	9d. Date signed (Mont Augus	h, Day, Year) 13, 2009	
	\ \ \		30. Name and address of person who completed cause of death (Item 23a) (Typ. Alan Sheff, MD 10215 Fernwood R	oad, #100	, Bethesd	a, MD 20	817		
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 17 2009  Registrar's Signature	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2-EDA /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 527 W. CEDAR HILRD. NNE ARUNDE 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex **Funeral** Year) Min 1 □ M 2 💢 F Months Days Hours 218-26-205 Usual Residence of Decedent -10 Director with the Maryland 10d. Inside City Limits show 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No HITE Specify δ 3 ₩idowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) filed 18. Mother's Name (First, Middle, Maiden Surname) 🥥 NK 17. Father's Name (First, Middle, Last) and 2 should be DIA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2426 ALMA RD. BALTIMORE, MD permit. Pages 1 and 2 Department of Health a Important: If Item 27 is DONNIE LOOM IS GRANDDAUGHTER or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 8-26-09 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RUNDER CREMATORY Injury ( 4 ☐ Donation 5 ☐ Other (Specify) COENTON, MD. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility DAUR LEATY FUNERAL HOME any ASADENA, MD. 21122 Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, on emplications tha shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy perform page After this certificate 1 □ Yes 2/No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 2ENO 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident

Box 68760, Ö ۵. Division of Vital Records,

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29a, Certifier

3 Suicide

4 Homicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

31. Date filed (Month, Day, Year) AUG 3

32. Registrar's Signature

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2009 0343  $A^{\mathsf{M}}$ Edith W. Short August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ceci1 E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, DEC 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Min. Hours Months 1 □ M 2 🗓 F 90 1918 Pennsylvania Director 181-07-1808 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expressor, must be notified at 1 ☐ Yes 2 No Director Rising Sun Marvland Ceci1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1881 Telegraph Road 21911 United States Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: ۵ If Yes, Give Year or Dates: 3 Midowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Jones Jesse Wooten, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any injury or other traur Renee Riley/Daughter 152 Cara Cove Road, North East, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 26 1 Burial 2 Cremation 3 Removal from State Lawn Croft Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Linwood, PA 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Sign ture of Funeral Service Licensee 21921 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardio pulmonary

Due to (or as a con equence of): arrest disease or condition resulting in death) /Medical Examiner espiratory in sufficience Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Preumonia requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) o the 9 Unknown been signed by is should be detach ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Severe arrest respiratory 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congestive 24a. Was an certificate has hein+ page 2 autopsy performed The Chance obstructure 2 No 1 ☐ Yes 2 ☐ No 1 □Yes Pulmonane Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ↑☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident the 1 Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide hours after within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 048 23 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Bow 21921 erru ecia Street MD 31. Date filed (Month, Day, Year) 32. Registra's Signature State

6 OK

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day\_ Month **Physician** Bradden August 2009 6:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday **Funeral** 1**X** XM 2 □ F NONE Yrs 7/24/2009 Director VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show aţ 1 ☐ Yes 2 💢 No notified Director WV BERKELEY MARTINSBURG 28a-f with the 10e. Street and Number 10g. Citizen of What Country? ö must be 25403 items 23a USA 569 TALISMAN DRIVE death v Funeral Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ral", or iten Examiner If Yes, Give Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify þ WHITE Specify. 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JENNIFER TINSMAN JAMES STAVELY, IV ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 569 TALISMAN DRIVE, MARTINSBURG, WV 25403 of Health item 27 i JAMES STAVELY, IV/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) TOMAHAWK CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State t ot = : 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 1, 2009 HEDGESVILLE, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Necrotizing enteroculitis Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner ematunt Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to for as a consequence of The law requires that the death certificate be executed physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) signed by the att Id be detached for 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: Other: 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\square$ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury s after death. 2 🗌 No 2 Accident 1 Tes the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide

24 hours To the Hosp within 24 hor To the Fune completely fi

> Registrar DHMH 17 Rev 1/2001

29a, Certifier

(check only one)

29b. Signature and title of certifier

Stephanie

31. Date filed (Month, Day, Year)

Medical

State

- SALA-BL

and manner stated

ranie de WH MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie de Wit

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Avaust 5, 2009

e Hospital or Attending Physician: The law requires that the death certificate be executed 2.4 hours after death.

Purneral Director: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Division of Vital Records, within 2

TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: A state of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the property of the cause (s). 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier\_ 2009 28281

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NET-SON BEN-TERS, 9131 PISCATALMY 2D, CLINTON, MI) 20 2-3.

State Registrar

Medical

31. Date filed (Month, Day,

32. Registrar's Signature Dane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a Per FH G895 9/01/09 JH
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar			rtificate of		Re	g. No. 🤈 🗍 [	19 27861
			1. Decedent's Name (First, Middle, Last,	)		2. Date of Death Month		3. Time of Death		
	Physici /Medio		Terry Wayne	Thompson				August	13, 200	
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of	Death
1			Garrett County Mc	emorial Hospi	ital		land		Garre	
	Funeral		Social Security Number     6. Security Number	x 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>		. Birthplace (State or Foreign Country)
	Director		578-70-9393	57	7 Yrs.			09/16/1	951 I	Pennsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10d. Inside City Limits
	daryi									1 ∐Yes 2√XNo
	the N	Director	Maryland St. Mar 10e. Street and Number	ry's	Califo	10f. Zip Code		10	og. Citizen of Wha	at Country?
	with ba or	Ö		3		,	0619		9	S A
	eath	Funeral	22567 Torino Road	12. Was Decedent Ever in	U.S. 13.		lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		American Indian,
(0	fter d	표	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Rican, etc.)	Black, 1	White, etc.
036	urs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1∐Yes 2∏ANo	Specify:		Specify:	White
21215-0036	2 ho	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occup	pation	20	16b. Kind of Busir	ness/Industry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of workird)	'9		
	ygien ygien ier th	Co	12		(	General M			*	ng Goods
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		·	
У	ould Mer narke	မ	George Marlin	Thompson			Alice	Elai		igart
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Eventher must be notified at		19a Informant's Name/Relationship (T) Jacinta Maria Thom Cindy B. Thompson	pson/wife	1		and Number or Rura			
	1 and Healt		20a. Method of Disposition			sition (Name of			20c. Location - Cit	
ŏ	tof if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, crei	matory or other place ate Heart	ce)			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral Service License	<u>'</u>	oi Mary		:08/18			n Park, MD
Bal	permi Depar Impor any ir		Jaklan 1111	×/~ \			.lywood Rd			Home, P.A.
			Edward N. Brins 23a. Part 1. Enter the disease, or compl				-			Approximate
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.						Interval Between Onset and Death
- Sp-	Physician /Medical		disease or condition resulting in death)	a. 250		EAL (	CANCE	٤		2 years
1	Examiner			Due to (or as a conse	equence or):					
		ē	Sequentially list conditions, if any, leading to immediate	bb. Due to (or as a conse	equence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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_	tifica ng ph as th	ledi								
Вох	eath certific attending p for use as t	J/N	23b. was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		☐ Ectopic pregnanc	71/		23d. Date	
	deat ne att	icis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of		Other (specify)	-y 		Month	n Day Year
P.0	at the by the	Physician/M	9 ☐ Unknown					Т		
	res that the de signed by the be detached	by F	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
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orc	0 0 0	12								
ecorc	law require las been si 2 should b	plet						24a. Was ar	y prie	ere autopsy findings available or to completion of cause of
I Record	The law recate has bee page 2 shot	Complete						autops perforn	y prid ned? dea	ere autopsy findings available or to completion of cause of ath?  ☐ Yes 2 ☐ No
ital Record	cian: The law rec ertificate has bee ctor, page 2 shot	Be Completed	25. Was case referred to medical				26. Place of Death	autops perform 1 □ Yes 2	y prioned? dea	or to completion of cause of ath?
of Vital Records,	<b>hysician:</b> The law <b>rec</b> this certificate has be <b>e</b> il director, page 2 shot	Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Impatient 2		III 3 LI DOA	ner: 4 \sum Nursing Ho	autops perform 1  Yes 2	y prioned? dea	or to completion of cause of ath? ⊒Yes 2 □No
o	ng Physician: The lar fter this certificate has neral director, page 2	To Be	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Inju	ner: 4 Nursing Horry at 2	autops perform 1 □ Yes 3 (Check only one me 5 □ Reside	y prinded? dea	or to completion of cause of ath? ]Yes 2 □ No ( <i>Specify</i> )
o	fe fe	To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Inju Wor M 1	ner: 4 ☐ Nursing Hor ry at k?  Yes 2 ☐ No	autops perform 1 Yes 2 in (Check only one me 5 Reside 28d. Describe ho	y prince 6 Other w injury occurred	or to completion of cause of ath?  ∐Yes 2 □ No  (Specify)
o	or Attending ter death. irector: Afte n by the fune	To Be	examiner? 1   Yes 2   No   1  27. Manner of Death 1   Natural 5   Pending	28a. Date of Injury	28b. Time of Injury	f 28c. Inju Wor M 1	ner: 4 ☐ Nursing Hor ry at k?  Yes 2 ☐ No	autops perform 1 Yes 2 in (Check only one me 5 Reside 28d. Describe ho	prince 6 Other winjury occurred	or to completion of cause of ath? ]Yes 2 □ No ( <i>Specify</i> )
Division of Vital Recorc	or Attending ter death. irector: Afte n by the fune	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury - At building, etc. (Spe	28b. Time o Injury home, farm, str cify)	f 28c. Inju Wor 1 □	ner: 4 □ Nursing Hol ry at : k?  Yes 2 □ No :	autops perform 1 Yes 2 n (Check only one me 5 Reside 28d. Describe ho 28f. Location (St. City or Town	prince 6 Other w injury occurred and Number s, State)	or to completion of cause of atth?  JYes 2 □ No  (Specify)  or Rural Route Number,
o	or Attending ter death. irector: Afte n by the fune	Certification: To Be	examiner?  1	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Spersician: To the best of my kiner: On the basis of exami	28b. Time of Injury home, farm, stroify)	f 28c. Inju M 1 □ reet, factory, office	ner: 4  Nursing Hol ry at k? K? Yes 2 No	autops perform 1 Yes 2 and (Check only one 5 Reside 28d. Describe house 28f. Location (St. City or Town and due to the c	prince 6 Other winjury occurred not Number n, State)	or to completion of cause of ath?  Yes 2 □ No  (Specify)  or Rural Route Number,
o	or Attending ter death. irector: Afte n by the fune	To Be	examiner?  1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigation 3   Suicide 4   Homicide   Homicide    29a. Certifier   Check only 2   Medical Examined	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At building, etc. (Spe	28b. Time of Injury home, farm, stroify)	f 28c. Inju M 1 □ reet, factory, office	ner: 4 Nursing Horry at k? k? lYes 2 No	autops perform 1 □ Yes 2 1 (Check only one me 5 □ Reside 28d. Describe ho 28f. Location (St. City or Town and due to the ced at the time, d	p prince of the	or to completion of cause of ath?  Yes 2 □ No  (Specify)  or Rural Route Number,
o	Hospital or Attending 24 hours after death. Funeral Director: Afte tely filled in by the fune	Certification: To Be	examiner?  1   Yes 2   No  27. Manner of Death  1   Natural   5   Pending investigation  3   Suicide   6   Could not be determined  29a. Certifier (Check only one)  1   Certifying Phyone	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Spersician: To the best of my kiner: On the basis of exami	28b. Time of Injury home, farm, stroify)	f 28c. Inju Wor M 1 Creet, factory, office	ner: 4 Nursing Horry at k? k? lYes 2 No	autops perform 1 □ Yes 2 1 (Check only one me 5 □ Reside 28d. Describe ho 28f. Location (St. City or Town and due to the ced at the time, d	p prince of the	or to completion of cause of ath?  IYes 2 □ No  (Specify)  or Rural Route Number,  mer as stated. d due to the cause(s)
o	or Attending ter death. irector: Afte n by the fune	Certification: To Be	examiner?  1   Yes 2   No  27. Manner of Death  1   Natural   5   Pending investigation  3   Suicide   6   Could not be determined  29a. Certifier (Check only one)  1   Certifying Phyone	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Spersician: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, stractify)  nowledge, deatination and/or in	f 28c. Inju Wor M 1 Creet, factory, office	ime, date and place, opinion, death occurres e number	autops perform 1 Yes 2 and (Check only one East. Location (St. City or Town and due to the ced at the time, d	prince 6 Other winjury occurred and Number state)  ause(s) and manuate and place, an end of the signed (	or to completion of cause of ath?  IYes 2 □ No  (Specify)  or Rural Route Number,  mer as stated. d due to the cause(s)
o	or Attending ter death. irector: Afte n by the fune	Certification: To Be	examiner?  1   Yes 2   No  27. Manner of Death  1   Natural 5   Pending investigation  3   Suicide 4   Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who continued	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - At building, etc. (Speriscian: To the best of my kiner: On the basis of examinand manner stated.	28b. Time of Injury  home, farm, stractify)  nowledge, deatination and/or in	f 28c. Inju Wor M 1 Creet, factory, office	ner: 4 Nursing Horry at k? k? lYes 2 No	autops perform 1 Yes 2 and (Check only one East. Location (St. City or Town and due to the ced at the time, d	prince 6 Other winjury occurred and Number state)  ause(s) and manuate and place, an end of the signed (	or to completion of cause of ath?  IYes 2 □ No  (Specify)  or Rural Route Number,  mer as stated. d due to the cause(s)

		_ FOI	epartment of Health and N Certificate of Death	/lental Hygiene Reg. No. 🤈 🎧	119 27865
Dhysi	oion	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
Physi /Med		Margaret Theresa Thompson		August 18, 200	
Exam	iner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
ale e		30720 Big Horn Court	Charlotte Hall		
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 215−26−3233 81 Y	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 23, 1928	9. Birthplace (State or Foreign Country) Washington, DC
ъ		Usual Residence of Decedent			
arylar show	-	10a. State 10b. County 10c. City, Town			10d. Inside City Limits 1 ☐ Yes ३√XNo
he M	ecto	Maryland St. Mary's Cha	rlotte Hall	10g. Citizen of V	
with i	Ö	30720 Big Horn Court	20622	U.S.A	•
leath	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		e - American Indian,
Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Event and also notified at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 및 No	If Yes, specify Cuban, Mexican, Puerto		k, White, etc.  White
Z1Z15-0U36 d within 72 hours aff giene. er than "natural", or , in widical Exam	ted	15. Decedent's Education 16a. I	Decedent's Usual Occupation	16b. Kind of Bu	usiness/Industry
K13 hin 73 e. an "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) A	Give kind of work done during most of work life. DO NOT use retired)		
A with year the transfer to the transfer the transfer the transfer the transfer the transfer the transfer the transfer transfer the transfer transf	ပ္ပ	12' A	ccounts Reeceivable		
be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surnam	
Maryland  nd 2 should be file with and Mental Hy 27 Is marked oth	မ	Edward Michael Flaherty		Margaret Wils	
Mal d2st d2st than than than traur			Mailing Address (Street and Number or Ru 710 Big Horn Court (		
Te, 1 an Heal tem 2			Disposition (Name of crematory or other place) 8-20-		City or Town, State
nol		TWO BURIAL 2 LI Cremation 3 Li Hemoval Irom State 1	s Memorial Gardens		town, Maryland
Saltimore, permit. Pages 1 ar Department of Hea Important: If Item:	nce.	21. Signature of Fungral Service Licenses Moo817	22. Name and Address of Facility Brinsfield-Echols P.O. Box 128 Char	1	
<b>a</b> answ	0	23a. Part 1. Enter the disease, or complications that caused the death. Do no			20622 Approximate
Physician /Medica Examine	il r	Due to (or as a consequence or			Interval Between Onset and Death U.M.Com
UNISION OT VITAI RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	d	f):		
the death certification to the attending of the attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		te of delivery onth Day Year
Records, P.O. The law requires that the defents been signed by the age 2 should be detached	ğ	Tartin Other significant conditions contributing to death out not resulting in	the underlying cause given in Part I.	23e. Did tobacco use cont	ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
w req	ete			24a. Was an 24b.	Were autopsy findings available
OT VITAL HEOPhysician: The lave this certificate has all director, page 2.3	Completed			autopsy performed?	prior to completion of cause of death? 1 □ Ye s 2 □ No
VITAI rsician: Ti s certificate lirector, pa	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	th (Check only one)	
OT Phys	은	1 ☐ Yes 2 ☐ Ho ☐ Hospital 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA 4 Nursing H	ome 5 A Residence 6 ☐ Oth 28d. Describe how injury occur	
on on ding Fig. 1. After funers funers	tion		ime of jury 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	25d. Dodding flow injury coods.	
DIVISION OT  I or Attending Phy after death. Director: After this d in by the funeral d	Certification: T	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Could not be determined  28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Numb Cify or Town, State)	per or Rural Route Number,
To the Hospital within 24 hours a To the Funeral ( completely filled	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge. 2 Medical Examiner: On the basis of examination and and manner stated.			
o the ithin 2 o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signe	od (Month, Day, Year)
F § F 8		A 2	Decerie	41	16/10
a	,	30. Name and add as of per hambo completed cause of death (Item 23a) (	Type, Print)	0/	( // 0 /
43		David ballation, 1	Type, Print)  6 Hosp. Fall Rd, Sun	e 310 Prince	Prederik, no
Regis	State	31. Date filed (Month, Day, Year)  AUG 2 0 2009	hadel		201

			1 - State of Ma		artment of Health and Artificate of Death	, ,	eg. No. On a on a company				
	Discorted		Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year				
	Physici /Medio		CHARLES LIN THOMPSON			AUGUST	T 14 2009 10:12 AM				
**	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death								
100	Funeral			e (In yrs. last birthday)	If Under 1 Year   If Under 24 H	rs. 8. Date of Birth	9. Birthplace (State or Foreign				
	Director		215-36-3253 1X M 2 F	69 Yrs.	Months Days Hours Mi	rs. 8. Date of Birth n. (Month, Day SEPTEMBER	22,1939 MARYLAND				
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits				
	death with the Maryland ms 23a or 28a-f show	JO.	MARYLAND CHARLES	WELCOME	541011		1 TopYYes 2 □ No				
	r 28a-	irect	10e. Street and Number	WILLCOILE	10f. Zip Code	1	0g. Citizen of What Country?				
	th with	<b>Funeral Director</b>	5980 FIRE TOWER ROAD		20693	U	NITED STATES				
	tems	uner	11. Marital Status 12. Was Decedent E Armed Forces?	Ever in U.S. 13. V	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	hours after t <b>ural", or ite</b>		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10	1 □Yes 2 █No Specify:		Specify: BLACK				
21215-0036	72 hou natura ficul E	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation		16b. Kind of Business/Industry				
215	thin 7 ne. nan "n	nple	Elementary/Secondary (0-12) 7TH GRADE College (1-4or 5	life. L	kind of work done during most of w DO NOT use retired)		DIDI TADICODV				
	led wi dygier her th	Co	17. Father's Name (First, Middle, Last)	SEKVI	CE STATION ATTEM	IDANI lame (First, Middle, M	FUEL INDUSTRY				
lanc	should be filed within and Mental Hygiene. marked other than imatic event, I.M.M.	To Be	JEREMIAH THOMPSON				OCTOR THOMPSON				
Maryland	ar is		19a. Informant's Name/Relationship (Type. Print) MARY R. THOMPSON / WIFE		ng Address (Street and Number or FIRE TOWER ROAD,						
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place)  EMORIAL GARDENS		20c. Location - City or Town, State WALDORF, MARYLAND				
Balti	permit. Departn Importa any inju		21. Mary ure of Funeral Service Central LATOLA C. THORNTON JOHNSO	)N 22 3	HORNTON FUNERAL 439 LIVINGSTON I	HOME, P.A	ÅN HEAD, MARYLAND 20640				
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each light	the death. Do not enter			est, Approximate Interval Between				
	Physician	i	Immediate Cause (Final disease or condition	e Resp	Tratory Fa	Sure	Onset and Death				
-	/Medical Examiner		resulting in death)  Due to (or as	consequence of)	Dan Shur E	- lower					
	The state of	er	Sequentially list conditions, if any, leading to immediate b. Due to (or see	a corseque ce of):	D. I.						
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	otic 8	hocks						
oʻ	e execu ian and urial-trar	I Ex	resulting in death) Last Due to (or as	a consequence of):	nonal La	slupe					
68760,	rificate be executed ng physician and as the burial-transit	edical	d. Colle	ONZe	renar fo	wire.					
			IF FEMALE: 23c. If yes, outcome	of pregnancy			23d. Date of delivery				
Box	The law requires that the death certi ate has been signed by the attending agge 2 should be detached for use a	Physician/M	in the past 12 months?  1 \sum \text{Live birth}  4 \sum \text{Pregnant at}	2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year				
P.0	at the by the tache	hys	9 Unknown								
	uires that the de signed by the a d be detached f		Part II, Other significant conditions contributing to death by	It not resulting in the ur	nderlying cause given in Part I.		pacco use contribute to the cause of death?				
oro	w requir s been s	sted	The second			1 🗆 Ye					
Records,	sician: The law certificate has t irector, page 2 s	Completed by	hyper /en sin			24a. Was a autops perforr	prior to completion of cause of				
Vital	ificate or, pag		25. Was cast referral to medical		00 Plans 445	1 □Yes	2 ☑No 1 □ Yes 2 □ No				
>	Physician: r this certifica ral director, p	To Be	examiner:	ent 2 ER/Outpatien	Othor	eath <i>(Check only on</i> Home 5□ Beside	ence 6 Other (Specify)				
Jo u	ng Ph fter thi		27. Ma er of Death 28a. Date of Inju Z Natural 5 ☐ Pending (Month, Da)	ry 28b. Time of			ow injury occurred				
Siol	tendir eath. or: Ai	catic	2 Accident investigation		M 1 □Yes 2 □No						
Division	or Attaffer d Direct In by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Si City or Town	treet and Number or Rural Route Number, n, State)				
_	To the Hospital or Attending Physician: The I within 24 bours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier Certifying Physician: To the best of Check only 2 Medical Examiner: On the basis of	of my knowledge, death	n occurred at the time, date and pl	ace, and due to the courred at the time.	rause(s) and manner as stated.				
	o the Hithin 24 of the Fi	Medical	one) and manner sta		29c. License,number		19d. Date signed (Month, Day, Year)				
9	- s - ō	ij	Syrhol Ck	coth (Hors 202) (T	D 37	114	8/14/2008				
1	003	Į.	30. Name and address of person who completed cause of description of the second	D. 70 p.	ost office	Road	Walderf, 4D				
	Sta		31. Date filed (Month, Day, Year) 32. Registra AUG 1 7 2009	ar's Signature	1.46		20602				
	Registr	ar	MUU I 1 2009 Kens	wa B. A	park						

			ricase	State of Ma			artment of h		-		_	
			For State Registrar	Oldio o. III	y (C.) (	•	rtificate of			Reg. No	711119	27867
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De	eath Day	/ Year	3. Time of Death
	Physici /Medio		Margaret		rott	enberg			August	13,	2009	10:30 A.M
	Examir		4a. Facility Name (If not institution, give				4b. City, Town, o		ath		County of Death	
			2201 Colston Driv 5. Social Security Number 6. S		e (In vrs. la	ast birthday)	Silver If Under 1 Year		rs. 8. Date of Bi		ntgomer	
	Funeral Director			□ M 2 🛣 F	85	Yrs.	Months Days	Hours Mi	n. (Month, D	ay, Year) 18. ]	9. Birth Con New	York
	D		Usual Residence of Decedent		1.0.00							
	arylar show	7	10a. State 10b. County		,	, Town or Lo						10d. Inside City Limits 1 ☐ Yes ※☐ No
	the M	ecto	Maryland Montgome  10e. Street and Number	ry	Sil	ver Sp	10f. Zip Code			10a Cit	izen of What Co	
	3a or	by Funeral Director	2201 Colston Driv	e. #206			20910				ed Stat	
	death	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or N		14. Race - Amer Black, White	ican Indian,
98	after or Ite	/Fu	1 Never Married 2 Married	1.A∏Yes 2 ☐ f	No		1 □ Yes 2 🛣 No		eno rican, ec.,		Specify:	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene.  do other then "natural, or items 23e or 28e-f show event, the Medical Exam hat must be notified at		3 N Widowed 4 □ Divorced	Year or Dates:	AMTT	16a Door	dent's House Occur	nation		16h K	Wh ind of Business/I	ite
5	in 72 n "nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of w d)	vorking	100. K	ilid oi busiiless/i	ndustry
212	filed within Hygiene.	om	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Secre	tary			Aca	ıdemia	
pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle	, Maiden	Sumame)	
yla	should be filed withir nd Mental Hygiene. s marked other then umatic event, the Mi	To	William Wilson						у МсКау			
Maryland	. a e 3		19a. Informant's Name/Relationship			19b. Mailir	ng Address <i>(Str</i> eet Duane Str	and Number or eet	Rural Route Numb	er, City o	or Town, State, Z	îp Code)
	Health tem 27 l		Mark Trottenberg, 20a. Method of Disposition	Son	20b. Pl	New Y	ork NY, esition (Name of matory or other pla		Date	20c. Le	ocation - City or 1	Fown, State
JOH.	ages ant of nt: If It y or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specification)		1		matory or other pla Cremator	110	G. 14,	C1.	n Burni	Manuland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Licer					200				e, Maryland
m	Per Per Per Per Per Per Per Per Per Per		1 Janu m	The 1	10150	8 9	Name and Addre Chibadeau 33 Gist	Ave., L	ry Servic L, Silvei	Se, E	ing, MD	20910
B,092	Physician and hybridar transit he burial-transit	cai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death)	a. CHRONIC  Due to (or as  Due to (or as  Due to (or as  d.	OBSTI a consequ a consequ	ience of):	E PULMON.	ARY DISI	EASE			Interval Between Onset and Death 6 YEARS
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending phy organs 2 should be detached for ure as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown Part II. Other significant conditions of	23c. If yes, outcome 1   Live birth 4   Pregnant at 9   Unknown	2 □ Fetal time of de	death 3[ eath 5[	Ectopic pregnanc		23a Did		23d. Date of deli Month	very Day Year the cause of death?
Records,	signe d be c	d by	HYPERTENSION, COR				, , ,	ren an rout.		_		bably 4 Unknown
COL	w requ	Completed	SENILE DEMENTIA						24a. Wa	s an	24b. Were au	topsy findings available
Re	The lay	dwo							- auto	opsy ormed?	prior to death?	ompletion of cause of
Vital		a	25. Was case referred to medical					26. Place of D	1 ☐ Yes Death (Check only	2 <b>X</b> □ No one)	T Tes	2 <b>X</b> №
Ţ	di is	To B	examiner? 1 ☐ Yes 2 <b>X</b> ☐ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatier	nt 3 DOA Oth	ner: 4 Nursing	Home 5 XRes	idence	6 □Other (Spec	eity)
n of	ding Ph h. After th funeral		27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Yea <i>r)</i>	28b. Time o Injury	Wo	rk?	28d. Describe	how inju	ry occurred	
sio	or Attending tter death. Director: After in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be		45 5			Yes 2□No	206 Leasting	/Ctroot or	ad Alumbas as Du	to I Douto Alvertos
Division	of or Attend after death Director: A	ertif	4 Homicide determined	building, et	c. (Specify	me, rarm, sti	reet, factory, office		City or To			ral Route Number,
_	Hospite 4 hours Funeral ely fille	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis o and manner sta	f examinati	wledge, deat ion and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ace, and due to the courred at the time	cause(s , date and	and manner as d place, and due	stated. to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	$\sim$			29c. Licens	se number	,	29d. Da	te signed (Month	n, Day, Year)
0	2		1 March C	Word	UI	UV	DI	16101		AUGU	ST 13,	2009
(	)	H	30. Name and ad re s of person wh									
			GAIL POVAR, M.D., 31. Date filed (Month, Day, Year)					400, SII	LVER SPRI	NG,	MD 2091	U
	Sta Registi		AUG 17 200	3. Registr	1	ha	Ked.					

atrick Jude Trace	1- For State Registrar	Department of Health a Certificate of Death		Reg. No. 2009 2786
Physician Medical Examine	Patrick Jude Tracey		2. Date of Dea Month July 31, 2	ath 3. Time of Death
	Facility Name (if not institution, give street and number)     3103 Anchorage Way	4b. City, Town, Ocean Cit	or Location of Death	4c. County of Death Worcester
Funeral Director	204-42-5616 <sub>1</sub> X <sub>M 2</sub> F 41	n yrs. last birthday)  Yrs.  If Under 1 Ye  Months  Da		irth (MM/DD/YYYY) 9. Birthplace (State or Foreign Supplied State or Foreign PA
uth the Maryland 23a or 28a-f show any notified at once. al Director	MD Worcester	Ocean City  Ocean City	21842	10d. Inside City Limits 1 译Yes 2 No 10g. Citizen of What Country? USA
hours after death wi "natural", or items Examiner must he ted by Funer:	3 VVIdowed 4 Divorced IT yes, Give Year or Dates:	No 1 Yes 2 X N	ation (Give kind of work done	White, etc.  Specify: White  16b. Kind of Business/Industry
ID 21215-0036 should be filed within 72 hour and Mental Hygiene. 7 is marked other than "natin event, the Medical Example To Be Completed		Chef	18.Mother's Name (First, Middle, Gloria Steinbe	erg
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than injury or other traumatic event, the Medical	Paul C. Tracey/Father  20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	20b. Place of Disposition (Name of corematory or other place)  Calvary Cemetery  22. Name and Address	may, that loral, pate 8/6/2009 ss of Facility	nber, City or Town, State, Zip Code) PA 15022  20c. Location - City or Town, State Pittsburgh, PA  6009 Harford Rd. 21214
Physician /Medical caminer	Michael Marzullo per DVR  23a. Part I. Enter the disease, or complications that caused the distinction of the failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  A Cardiac Arrhythmia Due to (or as a consequence of the following cause)  Myocardial Fibrosis  Due to (or as a consequence of the following cause)  C. Due to (or as a consequence of the following cause)	death. Do not enter the mode of dying not enter the dying not enter the mode of dying not enter the mode of dying	such as cardiac or respiratory arr	est, shock, or heart Approximate Interval Between Onset and Death
D. Box 68760, the death certificate be executly the attending physician and the for use as the burial - tra Physician/Medical	d.	g895 9-15-09 vt  Ectopic pregnancy  given in Part I. 23e. Did to	23d. Date of delivery  Month Day Year  bbacco use contribute to the cause of death?	
	Alcohol Use  25. Was case referred to medical	26 Disc.	1 ✓ Yes	an 24b. Were autopsy findings available prior to completion of cause of death?
Division of Vital happens of the strength of Attending Physician hours after death.  In meral Director: After this cert filled in by the funeral director Certification: To Be	examiner? 1  Yes 2 No  1  Accident  1  Pending Investigation  1  Pending Investigation  28  Place of Injury	2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Inju	yes 2 No	Residence 6 Other: Scene
	3 Suicide 6 Could not be determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my kno one)  2 Medical Examiner: On the basis of examinat.	wledge, death occurred at the time, d	or Town, S	e(s) and manner as stated.
To the H. within 24 To the FV. Completel	29b. Signature and title of certifier  Courable House  30. Name and address of person who completed cause of death	29c. Licens O.C.	se number M.E.	29d. Date signed (Month, Day, Year) July 31, 2009
State Registrar	Carol Allan, MD Assistant Medical Examine  31. Date filed (Month, Day, Year) 32. Degistrar's Sig		ore, MD 21201	
DHMH 17 Rev 1/2001	- Luis   Control	ORIGINAL		

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARGARET ELIZABETH TRENDLER AUGUST 2009 7:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country)

New York 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕅 F 172-24-3754 78 Sept 1 Director 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It's INs Jent Exa. ill et must be notified at MD Cecil Director Earleville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Model Exacult activust be notee. 2 Bohemia Lane 21919 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐Yes 2 ☐ No Specify: If Yes, Give Year or Dates: ð Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor of Patent & Design Museum 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Margaret Ferylein ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francis Pfeiffer (friend) 2 Bohemia Lane Earleville, MD. 21919 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Rose of Lima Cem. 8/29/09 Chesapeake City, MD. 4 Donation 5 Other (Specify) Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 21. Sign flure of Furreral Source Licensee M00510 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ST-ELEVATION MON disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) law requires that the death certificate be executed Exami LYMPHOMA physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p 23c. If yes, outcome of pregnancy \( \bigcup \big( A \\ 1 \bigcup Live birth \( 2 \bigcup Fetal death \\ 4 \bigcup Pregnant at time of death \\ 9 \bigcup Unknown \end{array} IF FEMALE: MA 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔼 No Month Year Day 5 ☐ Other (specify) P.O. s been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t , page 2 sl autopsy Hospital or Attending Physician; The certificate performe 1 ☐ Yes 2 🗷 № 1 ☐ Yes 2 X/Vo 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation hours after death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

ANMA 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMAL

Year!

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DHMH 17 Rev 1/2001

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Dr.

within 2

Dr. SAMANT, M.D

106

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year U9 OGELMAN OAN 0500 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood 8. Date of Birth (Month, Day, Year) Jan. 14, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) England 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Year) Months 1 □ M 2 □ F 215-40-6973 88 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 505 White Oak Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4or 5+) Banking Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ewart Annie Jane Hamer Briggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Bennett / Daughter 2808 Traxler Court Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August 17 2009 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licen Name and Address of Facility rranco & Sons, P.A. Severna Park Funeral Home 5 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death art 1 Enter the disease, or shock, or heart failure. List complications that caused the death. tonly one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediat Cause (Final disease or condition resulting in death) months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 $\square$ No 1 ☐ Yes

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Completed by

Be

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Department of Health and Mental Hygiene. Important: if item 271s marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Evantina In ust be inclined at once.

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examine physician and s the burial-transi Physician/Medical been signed by the should be detached Completed by this certificate has but director, page 2 st Be Certification: To After this funeral ours after death.

neral Director: Af
filled in by the fur

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 ☐ Unknown 25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 Dother (Specify) Other: 4 Nursing Home 5 Residence 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HUSE

29a. Certifier

1 Tes 2 No

27. Manner of Death

2 Accident

4 Homicide

3 Suicide

1 Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

26. Place of Death (Check only one)

29b, Signature and title of gertifier

determined

State Registrar 31. Date filed (Month, Day, Year)

ENTA MI

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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32. Registrar's Signature

445

within 24 hours a

Medical

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			For	State of Marylan	d / Depa	artment o	f Health a	and Me	ental Hygi	ene		
			1 - State Registrar		Ce	rtificate c	of Death		Re	g. No. 🤈 🕦	00	2787
П	Physic	ian	1. Decedent's Name (First, Middle, Las	st)				2	2. Date of Death Month	Day	Year	3. Time of Death
	/Medi		Allen Dale	Windsor, S	r.				August	14, 20	009	5:00 p <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give	,			n, or Location o	of Death		4c. County		.1
	<b></b>		24699 Horseshoe  5. Social Security Number 6. S		ast hirthday)	If Under 1 Ye	ements ear   If Under:	24 Hrs.   s	Date of Birth		Mary	lace (State or Foreign
н	Funeral Director			5x M 2□ F 51	Yrs.	Months Da		Min.	B. Date of Birth (Month, Day, 05/01/1		Cour	Maryland
			Usual Residence of Decedent						03/01/1	930		maryrand
	arylar show	<u>_</u>	10a. State 10b. County	10c. City	, Town or Lo	ocation					1	0d. Inside City Limits
	the Maryland 28a-f show	Director	Maryland St. Mar	y's (	lemen							1 ☐ Yes 2 🛣 No
	a or	Ö	10e. Street and Number	n 1		10f. Zip Cod			10	g. Citizen of W		try?
	hours after death with the Maryland tural", or items 23a or 28a-f show at Examinations the motified at	Funeral	24699 Horseshoe	Koad  12. Was Decedent Ever in U.	3 13		20624	gin? (Speci	ify Ves or No.		S A	an Indian,
(0	after dea or items	Fur	1 ★Never Married 2 Married	Armed Forces? 1 ∐Yes 2 🔀 No		Was Decedent of If Yes, specify C		i, Puerto Ri	can, etc.)		k, White,	
03	ral", o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2 <u>∏</u> 1	No Specify:			Specify:	W	hite
21215-0036	72 Inal	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Oc	cupation	t of working	11	6b. Kind of Bus	siness/Ind	dustry
121	within iene. <b>than</b> "	du	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work do DO NOT use rel	tired)	· or morning				
	Hygie Hygie ther t	ပ္ပို	17. Father's Name (First, Middle, Last)		]	Painter	19 Motho	r'o Namo (	First, Middle, Ma	Self-E	_	yed
ano	d be f antal red or	Be c		indsor				irley	,	Bosv		
Maryland	should nd Ma mark mark	욘	19a. Informant's Name/Relationship (		19b. Mailii	na Address (Stre			Route Number,			Code)
	nd 2 alth a 27 is 27 is r trau		Allen D. Windsor,		1				Clement	•		,
re,	item		20a. Method of Disposition	20b. P		sition (Name of natory or other p		Dat		Oc. Location - 0		
Ē	Page nent int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval from State		1d-Echo		08/19	/2009	Charlot	te H	all, MD
Baltimore,	permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 Is marked other the many injury or other traumatic event, Ins. Once.		21. Signature of Funeral Service Licen		22	2. Name and Ad	Idress of Facility	y ole Fi	ineral I	Home P	Λ.	
_	20 E # 9		Edward N. Brins	field, Jr. MOO	$052 \mid 3$	30195 Th	ree Not	tch Ro	d., Chai	rlotte	Hall	, MD 20622
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of	dying, such as	cardiac or	respiratory arres	st,		Approximate Interval Between
many.	Physician	Ш	Immediate Cause (Final disease or condition resulting in death)	a. RESYILA	+10R	-Y 7	本ルレ.	RE				Onset and Death
	/Medical Examiner	Ш	resulting in death)	Due to (or as a consequ	ence of):	11/2	1C Y	ــــــــــــ ما				Yence
		r e	Sequentially list conditions,	b. Due to (or as a consequ	ence of):	LUN	o o	1116)	18EM,			YEAR!
	uted d ansit	Ę.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· CMPONIC	LII	umoc	YTIC	CE	IKEM,	15	10	YEARS
oʻ	icate be executed physician and the burial-transit	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):		1110					
8760,	ate be nysicia ne bur	dical	(	d								
		Med	IF FEMALE:									-
Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	ncy death 3[	☐ Ectopic pregna	ancv			23d. Date		
0	the a	sici	1 Yes 2 No	4 ☐ Pregnant at time of d	eath 5	Other (specify	)			Mon	ith	Day Year
σ.	that the dened by the a		Part II. Other significant conditions of	entributing to death but not resu	Iting in the u	nderlying cause	given in Part I		23e Did toba	icco use contri	hute to th	e cause of death?
Records,	iires that signed I d be deta	d b		similaring to dout i but not resu	iting in the di	idenying cause	given in raiti.				3, ☑ Prob	
Sor	w requir been s should	Completed		<del></del> -		-					-	
Be	The law cate has page 2 s	m l							24a. Was an autopsy performe	l pi	/ere auto rior to cor eath?	osy findings available npletion of cause of
ta	ician: The certificate ector, pag	ပို	25. Was case referred to medical						1 ☐ Yes 2	<b>≥</b> No 1	□Yes	2 □ No
of Vital	Physician: r this certificaral director, p	(A)	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatier	st 3□ DOA (	Other		Check only one)  5 Residen			
100	ding Physi h. After this o funeral dire	Certification: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		njury at Vork?		d. Describe how			//
jor	uttendin death. ctor: Af y the fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury		vork? I∐Yes 2∐N	No				
Division	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, offic	ce	28	f. Location (Stre City or Town,	et and Numbe	r or Rura	Route Number,
D	ital o Irs af ral Di Iled ir							17/				
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	lical	(Check only 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinat	vledge, deatl ion and/or in	n occurred at the vestigation, in m	e time, date an ny opinion, deat	d place, an th occurred	d due to the car at the time, dat	use(s) and ma e and place, a	nner as s nd due to	tated. the cause(s)
	o the ithin (	Medical	29b. Signature and title of certifier	and manner stated.			ense number			d. Date signed		
	F ≥ F 8		224	Mi		230. 210	) Pare	71	290	-177 —	O a	oug, roat
	$\mathfrak{A}'$	-	30. Name and address of person who o	ompleted cause of death (Itom	23a) (Tune	Print)	1000	10	0 -	1/	_	
- {	X		LA MN DE	2 So GILL	N A	5	HM	ASSO	CIATES	Mar	evo	1000 M)

Registrar

State

31. Date filed (Month, Day, Year) AUG 20 2009.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Martin 2009 Joseph Willis, Jr. August 12, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home St. Mary's Charlotte Hall If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours Months 1**∑** M 2 □ F 416-20-4994 11/14/1924 84 Alabama Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Maryland St. Mary's Lexington Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 47988 Turkey Neck Road 20653 USA 12. Was Decedent Ever in U.S. Armed Forces? 1₩ 4es 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married & Married 1 ☐ Yes 21 No Specify Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Non Commissioned Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virgie Mimms Joseph Willis, Sr. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48181 Fairfield Way, Lexington Park, MD 20653 Marion G. Willis/Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 08/14/2009 Brinsfield-Echols Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signators of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Brinsfield, Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CVA 's Moltina Due to or as a consequence of): Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last lateral Due to (or as a consequence of): nd Stage Deni Due to (or as a consequence of) Dementra IF FEMALE: If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner The law requires that the death certificate be executed

**Physician** 

/Medical

10a, State

**Examiner** 

**Funeral** 

Director

28a-f show

ral", or items 23a or 28a-f shore Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examinar must once.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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with the Maryland

Examiner burial-trar attending physician for use as the buria Physician/Medical should be detached ğ Completed director, Be Certification: To

of Vital Records, P.O. Box 68760,

Division

cate has bage 2 s this certificate To the Funeral Director: After th completely filled in by the funeral Hospital or A 24 hours a

To the within 2

FRANCISCA State

Medical

2 Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifie

29449 CHARLOTTE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

D67814

CHARLOTTE

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d, Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUNEY 31. Date filed (Month, Day, Year)

6 ☐ Could not be

32. Registrar's Signature

and manner stated

DHMH 17 Rev 1/2001

Registrar

09-06351

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Webster 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day August 13, 2009 1916 hrs **Medical Examiner** William Ronald Webster c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Hebron 6850 Cherry Walk Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Min Months Davs Hours Director 10-14-1935 Maryland 1 X M 2 F 73 214-32-6037 Usual Residence of Decedent 10d. Inside City Limits Ob. County I0c. City, Town or Location any s 23a or 28a-f show a notified at once. Yes 2 X No Hebron with the Maryland Wicomico Director 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number USA 6850 Cherrywalk Road 21830 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status narked other than "natural", or items event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. hours after death Never Married 2 Married 2 X No Yes Widowed 4 X Divorce f Yes, Give Year Yes 2 X No specify: Specify: White permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 21215-0036 Insurance Salesman Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Webster David Swain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Brad Webster - Son 8<u>542 Riggin Road</u>, Mardela Springs, MD 21837 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) or other 1 X Burial 2 Cremation 3 Removal from State 8-18-2009 Hebron, Maryland Hebron Cemetery Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Bounds Funeral Home Main Street, Salisbury, Maryland 21804 23a/Part I. Enter the disease, or corporcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and transit Ca UNPENDED AMENDED attending physician or use as the burial Physician/Medi Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Month Day Year Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 Unknown g Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 V No 3 Probably 4 Unknown Hypertensive atherosclerotic cardiovascular disease Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? this certificate has performed? ✓ Yes 2 ~ Yes ne Hospital or Attending Physician: Ti n 24 hours after death. re Funeral Director: After this certifica letely filled in by the funeral director, pa 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 V Other: Scene DOA Inpatient 2 ER/Outpatient 3 1 V Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Subject pinned under lawn mower and FOUND: Natura Pending Yes 2 V No submerged in water Aug 13, 2009 1900 hrs 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 6850 Cherry Walk Road, Hebron, MD determined (Specify) Creek Embankment Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 14, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME 2006

State

31. Date filed (Month.

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32. Reg

strar's Signature

09-06639 Cheryl Sue Wilhelr	Please Type or Print in Black Indelible Ink.		gible.
Cheryi Sue Willien	State of Maryland / Department of He  1- For State	ath	eq. No. 2009 2787
Physician	Decedent's Name (First, Middle,Last)	2. Date of Dear	th 3. Time of Death
Medical Examine	- Cheldishe Willelin	y, Town, or Location of Death	4, 2009 2112111S 4c. County of Death
1		mberland	Allegany
Funeral Director	MC MC	Inder 1 Year If Under 24Hrs. 8. Date of Bir	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	Usual Residence of Decedent	1/2/13	5/1969 Country) Mary and
any	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
land from	Maryland Allecanu Lor	nacanina	1 Yes 2 No
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. them 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	10e. Street and Number	Zip Code	Og. Citizen of What Country?
with the is 23a centification		edent of Hispanic Origin? (Specify Yes or No	o- 14. Race - American Indian, Black,
or items 23	1 Never Married 2 Married Armed Forces? If Yes, sp	ecify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 No specify: ual Occupation (Give kind of work done	Specify: 16b, Kind of Business/Industry
72 hour	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	working life. DO NOT use retired)	Tob. Kind of Business/industry
5-0036 led within 72 hour Hygiene. tother than "natu the Medical Exam	18 2 -	Teller	Bank
215-C 215-C be filed v mtal Hygi rked othv ent, the J		18. Mother's Name (First, Middle,	Maiden Sumame)
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygier Browners in the marked other than "naturest", injury or other traumatic event, the Medical Examines To Re Compileted by		ress (Street and Number or Rural Route Nur	mber, City or Town, State, Zip Code)
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more, Pages I an nent of Hes ant: If ite	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (crematory or other place)		20c. Location City or Town, State
altimo mit. Pag spartment sportant: jury or or	4 Bollation 5 Totaler Specify.	metery 128, 2009 and Address of Facility	Frastburg, Mayland
Balti permit. Departn Imports injury o	Bondibulham 8600	MIN SKEPT LOCOM	1- makentale
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/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	vascular disease	Death
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red nsit Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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). Bo) it the death by the attracted for Physics	1 1 Yes 2 V No Q Linknown		
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Division of N ppital or Attending Phy nours abter death. real Director: After the filled in by the funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	1 Yes 2 No	now injury occurred
Division tal or Attendin ts after death. al Director: /	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac	tory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a (Check only) one)    Medical Examiner: On the basis of examination and/or investigation, i		
To with To con	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	(Granhshen)	O.C.M.E.	August 25, 2009
	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MD 21201	
State			
Registra	A THE OUT ON MAIN AND A SECOND AND ASSESSMENT	End.	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH 6896 ±0/65409 with and Mental Hygiene

Registrar  1. Decedent's Name (First, Middle, Last)	f Death Reg. No. 2009 27875
	2. Date of Death 3. Time of Death
Physician /Medical Rodney Lee Yoder	Month Day Year August 17, 2009 10:45 p
	or Location of Death 4c. County of Death
	.fornia St. Mary's
<b>Director</b> 278-18-1776 1 X M 2 □ F 87 Yrs. Months Days	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland St. Mary's California	1 □Yes 25No
Maryland St. Mary's California  10e. Street and Number 10f. Zlp Code	10g. Citizen of What Country?
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23293 By the Mill Road  20  11. Marital Status  1 Never Married  2 Married  1 TS/Yes 2 No  1 Never Married  2 Married  1 TS/Yes 2 No	Hispanic Origin? (Specify Yes or No-
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日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日本 日	18. Mother's Name (First, Middle, Maiden Surname)
Daniel Yoder  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Stree	Katie Poland
Z 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	et and Number or Rural Route Number, City or Town, State, Zip Code)
Dana Davis/Daughter 23293 By the 20a. Method of Disposition (Name of Dis	e Mill Rd., California, MD 20619 Date 20c. Location - City or Town, State
	08/21/2009 Leonardtown, MD
21. Signature of Funeral Service Licensee 22. Name and Addr	ress of Facility Brinsfield Funeral Home, P.A.
Manuelly Lange 1101403 22933 Hot	llywood Rd., Leonardtown, MD 20650
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval Between
resulting in death) a.	Teant Failure Onset and Death
Examiner Planterm (91)	
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25. Was case referred to medical examiner?  Hospital: Hospital: 4 [] Hospital: 4	26. Place of Death (Check only one)
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29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29a. Certifler (Check only one)  29b. Signature and title (Check only one)  29c. Licent	opinion, death occurred at the time, date and place, and due to the cause(s)  se number  29d. Date signed (Month, Day, Year)
29a. Certifler (Check only one)  29a. Certifler (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.  29b. Signature and title of certifier  29c. Licens  29c. Licens	opinion, death occurred at the time, date and place, and due to the cause(s)  se number  29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	opinion, death occurred at the time, date and place, and due to the cause(s)  se number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18, 2009 **Physician** Ama Stanley Anthony Zelenski 1: 250 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 10, 1 Talbot Hospital lemorial 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Ow York 1 3 M 2 ☐ F 077-18-5647 84 1925 New Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exeminer must be notified at Director MD Caroline Federalsburg 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 404 Old Denton Road 21632 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ☐ No
If Yes, Give 1 43-46
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ I If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than ' College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, Item 2008. Restaurant Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Antone Zelenski Eva M. Sobocinski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Hunt/ Daughter 3304 Scimitar Way, Greenbackville, VA 23356 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Sh. Veterans 08/24/09 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Eskon 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ocar disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ovenau Examiner Due to (or as a consequi) Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: 2 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

elenski

State Registrar

31. Date filed

29b. Signature and title of certifier

30. Name and address of person wh

Registrar's Signature

leted cause of death (Item 23a) (Type, Print) Centreville,

HO057821

MD

			For State		State of M	arylar		artment of I rtificate of			lental Hy	_	000	0 07	071
			Registrar  1. Decedent's Name	(First, Middle, La	st)			imodic or	Douil		2. Date of De		<u> </u>	3. Time of	f Death
	Physici /Medi		Pau1	Gerald	Amirau						AUGUS1	Day 2		2 08:3	32 AM
	Exami	er		_	e street and number, gton Medic		enter	4b. City, Town, o		n of Death Surnie	2	4c.	County of Dea	<sup>th</sup> e Arund	e1
	Funeral Director		5. Social Security No. 218-56-0	umber 6. S			last birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs.	8. Date of Bin (Month, Di 04/19	ay, Year)	9. Bii	thplace (State ountry) MA	
	pu:		Usual Residence of 10a. State	Decedent 10b. County		100 Ci	ty, Town or Lo	antion						10d. Inside C	ity Limite
	//arylan f show	ō	MD MD	,	Arunde1	100.01	ty, Town or Lo		a Bur	nie					Z∏ No
	r 28a-	irect	10e. Street and Num		Munder			10f. Zip Code	.r bur	HIC		10g. Citi	izen of What C	ountry?	
	th with	alD	3022 Fo	xtail La	ne				2106	1			U.	S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Eventinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Decedent Armed Forces? 1 ☐ Yes 2 2 If Yes, Give Year or Dates:	Everin U No		Was Decedent of Information of Info			ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whit Specify:		
Maryland 21215-0036	thin 72 hou e. an "natura Modic II	Completed	(Speci	15. Decedent's Ed	ucation	5+)	(Give	dent's Usual Occup kind of work done OO NOT use retire	during mo	ost of work	ing	16b. Ki	nd of Business		
21	filed within Hygiene. Ither than "				2			District						tail	
and	d be fil	Be	17. Father's Name (								e (First, Middle Muise	, Maiden	Surname)		
ar 2	12 should be filed within hand Mental Hygiene. 7 is marked other than "traumatic event, the Mental	2	19a. Informant's Na		Type. Print)		19b. Mailir	ng Address (Street				er, City o	r Town, State,	Zip Code)	
ΣŽ	and 2 ealth a n 27 is	1 1	Mrs. Che	ryl Amira	ault / wif	Ee	802	2 Foxtai	l Lan	e,	Glen	Burn	n <b>ie,</b> Ma	ryland	21061
Baltimore,	ges 1 nt of H if iter or oth	) "X	20a. Method of Disp 1 ☐ Burial 2		Removal from State	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ce)		Date .	20c. Lo	cation - City or	Town, State	
III.	permit. Pages 1 Department of H Important: If ite any injury or ot		4 ☐ Donation  21. Signature of Fur	5 ☐ Other (Specify		At		Cremator . Name and Addre	-		3/09			nie, MD	
Ba	any perm		1	al Au	Van	Ma		ingleton		_	2nd Av			n Burni es, P.A	
			23a. Part 1. Enter the	e disease, or comp trailure. List only	olications that cause one cause on each li	d the deat		72						Approximat Interval Bet	te tween
	Physician /Medical		Immediate Cause (I disease or condition resulting in death)		a. SUSPE			OCARD	MAL	- 10	ICARC	27 (6	N	Onset and I	Death
7	Examiner				Due to (or as	a conseq	uence of):								
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_		Medi	IF FEMALE:		u. ,										
O. Box	the death certiff y the attending ched for use as	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pregnand Other (specify) _	су				23d. Date of de Month		Year
rds, P.	law requires that the de as been signed by the 2 should be detached	ρ	Part II. Other signific	cant conditions co	ontributing to death b	ut not res	ulting in the ur	nderlying cause giv	en în Part	1.		tobacco u Yes 2	-	o the cause of c	
Division of Vital Records,	2 33 8	Completed										psy ormed?	24b. Were a prior to death?	utopsy findings completion of c	available ause of
/ital	clan: ertifica ctor, p	BeC	25. Was case referre examiner?	ed to medical						ce of Deatl	1 ☑ Yes ∩ (Check only o	2 □ No one)	I IEITE	s 2□No	
of/	Physician: r this certifica ral director, p	၉	1 ✓ Yes 2 ☐ N 27. Manner of Death	10	Hospital: 1 Inpation		ER/Outpatien			T			6 ☐ Other (Spe	ecify)	
lon	nding th. :: After e fune	tion	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da		Injury	28c. Inju Wor M 1 □	ryan k? lYes 2.[	_	28d. Describe	now injur	y occurred		
Divisi	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specif	ome, farm, stre y)	eet, factory, office			28f. Location ( City or To			ural Route Num	ıber,
	the Hospition 24 hour the Funer of the Funer of the Funer of the funer of the fill of the	Medical (	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best liner: On the basis of and manner st	of examina	wledge, death ition and/or inv	occurred at the ti	me, date a opinion, de	and place, eath occur	and due to the red at the time,	cause(s) date and	) and manner a I place, and du	s stated. to the cause(s	ş)
	Voit To 1	≥	29b. Signature and to	Itle of certifier	1. o ^	1D		29c. Licens	e number 177 <i>6</i>				te signed (Mon		ì
	Vol	1	30. Name and addre	es of person who			n 23a\ (Tupo I							2005	
	10 +		30. Name and addre					7 CHIC	HWY	1 01	7SAD	ENA	+, MD	21122	۷
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DHMH 17 Rev 1/2001

**O**RIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 13:54 PM Amend George W 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral 1**√2 M 2 □ F Months Days Hours Min 219-01-7094 Director 87 June 6,1922 Maryland Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits show ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Mickel Examiner must be notified at 1 ☐Yes 2X No Director Maryland Maryland Baltimore Co Baltimore Co. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States Funeral 7257 Bridgewood Drive death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 □No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. ģ Specify. 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Martin Marietta</u> Assembler 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic eve once. Elizabeth Dougherty ျှ William Amend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 7257 Bridgewood Drive 21224 Rose M. Amend (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hilltop Service Corp. 5 ☐ Other (Specify) 8/31/09 Towson Maryland 4□Donation 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue
Dundalk, Maryland 21222

Approximate 21. Signature of Funeral Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hemorrhage Pulmonary hour resulting in death) /Medical Due to (or as a consequence of): Examiner 3 hours Pneumonitis Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) P.O. 1 Tyes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by Gastroentestinal 1 🗌 Yes 2 X No 3 Probably 4 Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Cancer olon 1 X Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in the completely filled in the complete of the co death. 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-OCO D.O. 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore 4940 Eastern Elfrey D.O. Kate 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 970 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:43 PM **ANDERSON** AUG 2009 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F Days Director 226-48-2955 81 12-15-1927 VA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or Items 23a or 28a-f shov 1 XYes 2 No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 1901 ELGIN AVENUE 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 【No Specify: Specify: 3 Widowed 4 □ Divorced BLACK "natural" other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING 10 DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SOLOMON HARRISON QUEENIE JORDAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau BALTIMORE, MD 21201 MYRA MACON/NIECE 712 VINE ST. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 X Removal from State PLEASANT GROVE BAPT. 9-4-09 DREWRYVILLE, VA 4 Donation 5 Other (Specify) JAMES A. MORTON & SONS F.H., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 23a. Pargi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE RENAL DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Indescent Anthropology, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 3 Probably 4 ☐ Unknown ADVANCED EMPH-ISENA 1 ☐ Yes 2 ☐ No page 2 should Completed peen OGILVIE'S 24b. Were autopsy findings available prior to completion of cause of death? NDROI 24a. Was an has autopsy performe this certificate 1 ☐ Yes 2 Ø No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Man or of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending I after death. Natural (Month, Day, Year) Injury 5 Pending ✓ Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

CALVIN

31. Date filed (Month, Day, Year)

3.

SEP 0 1 2009

DHMH 17 Rev 1/2001

CATON

AVENUE.

900

32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DAVID

AUG. 28

BALTIMORE

2009

21229

MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Victoria S. Baquol 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medica Center Anne Arundel Glen Burnie | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | May 5, 1943 9. Birthplace (State or Foreign Delaware 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🖫 F 212-42-7867 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Anne Arundel 0denton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21113 8615 Wandering Fox Trail #106 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Sikorski Doris Muhl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8118 Buttercup Lane East, Pasadena, Maryland 21122 William F. Spies, III/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 31 2009 4 ☐ Donation 15 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 ponths? Day 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tastasic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐧 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred

burial-tran Division of Vital Records, P.O. Box 68760, the attending ph for use as th ed by the a detached f certificate has page, Physician: director. After this funeral or Attending

s after death.

To the Hospital or within 24 hours af To the Funeral D

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filled in by

completely

Examiner Physician/Medical Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

10

than "natural", or items 23a

Health and Mental Hygi em 27 is marked other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any in|ury or other tra

**Physician** /Medical Examiner

1 and 2 should be

21215-003

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event, the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

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þ Completed

29a. Certifier

25. Was case referred to medical examiner? examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 3 ☐ Suicide 4 ☐ Homicide

6 ☐ Could not be determined

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🗆 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7003274

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of pers 0

Medical

MARIA GAVIRIA 31. Date filed (Month, Day, Year) State

301 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ D. Brown Linda September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Gilchrist Towson Center If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In yrs, last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F New Jersey Months Hours March 30, 1948 Director 149-40-9159 61 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Tes 2 No Crisfield Maryland Somerset 10e. Street and Number 10g. Citizen of What Country? Funeral 21817 United States 3288 Sackertown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces 1 Never Married 2 Married Š 2 X No \_\_ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Elementary/Seconday (0-12) Teacher's Aide Day Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Solomon Scott Juanita E. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5007 Stowe Derby Dr., Charlotte, North Carolina 28278 Valerie L. Scott/ Sister 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Amanda Heaston <u> 299 Frederick Road, Baltimore, Maryland</u> 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and L. th shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a sequence of): Examiner Sequentially list conditions. Examine n any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death een signed by the 9 Unknown 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Resons terrombo embolico 24a. Was an pege 2 s certificale has autopsy perform Hospital or Attending Physician: The Yes Division of Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Matural injury 5 Pending Investigation Accident within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State, Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signa 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ 29, 2009 Charles Miller Bransfield 5:45 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Gilchrist Hospice Towson 5. Social Security Number 6. Sex 1 Å M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours SEPT. TO Year 918 391-12-0135 90 Chicago, Ill. Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Miami-Dade Florida Miami Beach 1 ☐ Yes 2 ₺ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20 Island Ave. Apt. 持614 33139 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Was Decreue...

Armed Forces?

1 Yes 2 No W.W.II 14 Bace - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (3-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Mohican Oil Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael James Bransfield Anita Marie Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marquerite B. Miller (Daughter) 17000 Wesley Chapel Road Monkton, Maryland 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Evans Funeral Chapel 31, 1 Burial 2 Tremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facility tives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093. 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ anemia disease or condition resulting in death) KNOW Medical Due to (or as a consequence of): Examiner hematuria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and I-transit bladder canc Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Month Dav Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe artery disease luna 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case re rred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospice ျင 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

(Check

29b. Signature and title of certifier

esecca

Date filed (Month, Day,

Year)

#410,S

harle

29d. Date signed (Month, Day, Year)

Cartifying Nursa Practioner: To the best of my knowledg

6

32. Registrar's Signature

01

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19b per fh 8895 9-3-09 vt

		1- State of Mary	•	artment of Hear tificate of De		Re	ene g. No. 2 () () ()	27833
Physic /Med		1. Decedent's Name (First, Middle, Last) Richard Walter Bur	rton			2. Date of Death Month August	30,2009	3. Time of Death 9:00 AM
Exam		4a. Facility Name (If not institution, give street and number) 3203 Northwind Road		4b. City, Town, or Loc	cation of Death		4c. County of Death	imore
Funera Directo			yrs. last birthday) 74 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct.15,	Year) 9. Birth Cou 1934 Mary	olace (State or Foreign ontry) yland
rland ow		Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town or Lo	cation				0d. Inside City Limits
e Mary Ba-f sh	Director	MD Baltimore		Parkvi			1 □Yes 2 No	
ath with the Marylan ; 23a or 28a-f show	I Dire	10e. Street and Number 3203 Northwind Road		10f. Zip Code 2123	4	10	g. Citizen of What Cou USA	ntry?
er de	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		I Was Decedent of Hispa f Yes, specify Cuban, N		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
213-0036 in 72 hours aft n "natural", or Medical Exerci	ted	15. Decedent's Education (Specify only highest grade completed)	i (Give	dent's Usual Occupatio kind of work done durin DO NOT use retired)	n ng most of workir		6b. Kind of Business/Ir	•
d Z1Z1 filed within Hygiene. other than "	Com	12 4	Ac	ccountant		/First Adiabatic Ad	Accounti	ng 
land Id be file lental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Walter Burton			Fdna Fl	(First, Middle, M annery		
NIGITY d 2 shou th and M T is mar traumat	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin <b>3203</b>	ig Address (Street and	Number or Rura	Il Route Number,	City or Town, State, Zi	Code)
baltimore, Maryland 2121: permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "r any lnjury or other traumatic event, the Med		Dorothy Burton-wife  20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Ob. Place of Dispos			ate 2	oc. Location - City or Tournbalk, Maryla	own, State
Dealth. Permit. Popartm. Importar any Injur.		21. Signature of Funeral Service Licensee		Name and Address of Vans Funera		8800 el Parky	Harford Ro Ville,Maryl	ađ and 21234
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Time rate Cause (Final isseries or condition residing in death)  Due to (or as a condition)	LZHIT	er the mode of dying, s IEL <sup>S</sup> DE	such as cardiac c	r respiratory arre	st,	Approximate Interval Between Onset and Death
ifficate be executed XX gphysician and XX as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a condition of the						
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	hysician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv	rery Day Year
requires that been signed to should be detailed.	by P	Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderlying cause given i	n Part I.	23e. Did tob 1 ☐ Ye	acco use contribute to s 2 <b>∑</b> No 3⊟ Pro	the cause of death?
ar necoln: The law rec ficate has bee r, page 2 shou	Completed					24a. Was an autopsy perform 1 □ Yes 2	prior to co death? No 1 □ Yes	opsy findings available ompletion of cause of
I VIL Iysiclai iis certii directo	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 2 No Hospital: 1 □ Inpatient	2 ER/Outpatien	1		n <i>(Check only one</i> me 5 <b>X</b> Reside	nce 6 □Other <i>(Spec</i>	ify)
nding Phy ath. r: After this	ation:	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day, Yea	ar) 28b. Time of Injury	Work?	: 2 □No	28d. Describe ho	w injury occurred	
LIVISI tal or Atter is after dear al Director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (S	At home, farm, streepecify)	eet, factory, office		28f. Location (Str City or Town	eet and Number or Rui State)	al Route Number,
ne Hospit n 24 hour ne Funera	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my one)  Certifying Physician: To the best of my one and manner stated.						
To the within To the comp	Me	29b. Signature and the of certifier  And  17 Q		29c. License nu	umber 23263	_	d. Date signed (Month)	Day, Year)
7		30. Name and thress of person who computed cause of death	(Item 23a) (Type,		ent M.	-	SON MO.	21204
St Regis	ate trar	31. Date filed (Month, Day, Year) 32 Registrar's S	Signature	~ 0				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔎 🛙 Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 087-38-6920 New 1 □ M 2 🔽 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified the once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No Bro? Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1233 Maco Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No f Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) istan 12 Lega 18. Mother's Name (First, Middle, Maiden, Surname) 17. Father's Name (First, Middle, Last) Be ဥ arri 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) prother 627 arrih 20b. Place of Disposition (Name cemetery, crematory or oth 20a. Method of Disposition 1 Durial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funery Service L R 21217 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician unknown /Medical Due to ( as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi signed by the attending physician and be detached for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 No 3 ☐ Probably in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5,10f&19b Per FH C895 9/10/09 JH
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Cei	rtificate of Death		3. No. 2009	27885
	Physicia		1. Decedent's Name (First, Middle, Last) <b>Wilhelmina</b>	Chaney		2. Date of Death Month August 31	Day Year 2009	3. Time of Death 6:00a M
and the same of	/Medic Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	1
, apr			249 Asbury Road	7 Ann II was loot high day)	Pasadena If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Arur	ndel  nplace (State or Foreign
	Funeral Director		114-14-0302	M 2 TF 7. Age (In yrs. last birthday)  92 Yrs.	Months Days Hours Min.	February 1	5,1917 Mai	ryland
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	e Man sa-f sh tiffed	ctor	Maryland Anne Aru	ndel Pasadena	a			1 □Yes 2 No
	with th	Funeral Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Co <b>nited</b> St	
	ns 23	eral	249 Asbury Road	Was Decedent Ever in U.S. 13. \	21230 21122 Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puert		14. Race - Amer	rican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a fredical Exaction content is indifficult at 000ce.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 🕱 No	f Yes, specify Cuban, Mexican, Puert 1 □Yes 2 <b>⊠</b> No <i>Sp</i> ec <i>ify:</i>	o Rican, etc.)	Black, White	hite
15-0	72 hc	letec	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	rking	6b. Kind of Business/I	ndustry
212	within jiene. r than	Completed by	Elementary/Secondary (0-12)		emaker		Own Home	
Maryland 21215-0036	d be filed antal Hyg ced other c event,	To Be C	17. Father's Name (First, Middle, Last) Charles Herget		18. Mother's Nar Margare	me (First, Middle, Ma et May	aiden Surname)	
<b>Jary</b>	2 should h and Me 7 is mark raumati	ĭ	19a. Informant's Name/Relationship (Typ	oe. Print)  erg/Daughter 249	ng Address (Street and Number or Ru			
ē,	f Healt F Healt tem 27		20a. Method of Disposition		sition (Name of	Date 2	Oc. Location - City or	
Baltimore,	Pages ment or ant: If i		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	Metro Cre	natory, Inc. 20		altimore,N	
Balt	permit Depart Import any Inj once.		21. Signature of Funeral Service License	Alice Iser	Name and Address of Facility Cemation Society 99 Frederick Road	ty of Ma Baltimo	ryland, re,Maryla	Inc. nd 21228
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not ent				Approximate Interval Between
-	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ventricular	Arry-MMic	λ		Onset and Death Minute
				Due to (or as a consequence of):	Rid Profix	ease		vears
	± q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	criery wis			
23.	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
68760,	rtificate be executed ng physician and as the burial-transit	calE	<b>€</b> d					
		Medi	IF FEMALE:					
Box	eath cer attendir for use	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
P.O.	that the de ned by the a detached t	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	South (Specify)			
Records, F	ig be	ρ	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to s 2 ⊠No 3 □ Pr	the cause of death? obably 4 Unknown
eco	e law requir has been s e 2 should	Completed				24a. Was an autopsy		topsy findings available completion of cause of
E B	: The cate h	Com				perform 1 □ Yes 2	ed?// death?	·
VII.	Physician: r this certific ral director, I	Be c	25. Was case referred to medical examiner? 1 ☐ Yes /2 ☐ Mo	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other:	ath (Check only one	) nce 6 □Other (Spe	-(4.)
ιof	ng Phy ter this neral c	n: To	27. Manny of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury	IL O BOA 4 INdising I	28d. Describe how	( )	cny)
Siol	Attending or death. ector: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1 □Yes 2 □No			
Division of Vital	To the Hospital or Attending Physician: The I within 24 brouts after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification: To	4 Homicide determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City or Town,	eet and Number or Ru State)	ıral Houte Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (		siclan: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.				
	To the within ?	Mec	29b. Signature and title of certifier	And manner stated.	29c. License number	29	d. Date signed (Mont	h, Day, Year)
	. 21.0		> H/10 3e	Hullel MD	Da2102		8/31/	9
	10		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	Print FOX+O	ue Ba	20 himu	eMD LI23
ì	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	bastol			

the Wilhemena Chaney 8131/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Andrew Thomas Cummings, Sr. 2. Date of Death 3. Time of Death Month 0337 2009 August County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Co. Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 11, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number Sex. 12 M 2□F 7. Age (In yrs. last birthday) 93 yrs. 220-34-6849 1916 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Harford Co. Street Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21154 United States 3073 Sandy Hook Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XNo Specify Specify: White ð 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farm Dairy Farmer 12 N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Curmings Mary Morrison ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Bernadette Court, Forest Hill, MD 21050 Mr. Andrew Curmings, Jr. (Son) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Bel Air, Maryland Sept. 2,2009 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Land & Cremation Services - Belair 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part1. Enter the disea e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of rigury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 🗆 Live birth 2 🗀 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Monny r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examine law requires that the death certificate be executed attending physician Physician/Medical ģ þ signed \$ Completed been has The this certificate Physician: Be Certification: To filled in by the funeral Prospital or Attending Programme 24 hours after death.
Funeral Director: After to e Funeral I Medical completely within 2 To the I

Records,

Vital

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Division

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or items 23a or 28a-f show the Wedicel Exeminer must be rediffed at

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than '

or other traumatic event,

permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau

**Physician** /Medical

Examiner

Maryland 21215-0036

Baltimore,

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State Registrar

29a, Certifier

29b. Sign

(Check only one)

itle of certifier

and manner stated.

500 Ypper Chesapeake

32. Registrar's Smatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Drive Bel AIR, MD 21014

29d. Date signed (Month, Pay,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24 2009 Charles D. Carroll /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A **Baltimore** 602 Lucia Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min Months 1 🕱 M 2□ F Director Feb 21, 1951 58 Maryland 214-56-5682 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemilmen must be rediffed at 1 ☐ Yes 2X No Director Baltimore Maryland **Baltimore City** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21229 602 Lucia Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 2 Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, In Im. Johns Hopkins Hospital Claims Dept. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aletha Carroll William Carroll ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Lucia Avenue Baltimore, Maryland 21229 Diane M. Carroll 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 09/03/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A.

1300 Eutaw Place Baltimore, Md 2121

330. Part 1. Enter the disease, or complications that caused the death. District the mode of dying, such as cardiac or respiratory arrest, smediate Course (Final) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TO Minutes /Medical Due to (or as a consequence of): Examiner DNE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: nse s If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1 ☐ Yes 2 🗖 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tyes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 X Natural 1 □Yes 2 □ No death. neral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined l or A 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

Vileuns

29b. Signature and title of certified

PALTIMORE 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 28 Day 0 0 9 Year Curtis Cecilia $\mathbf{E}$ 4:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Summerville Assisted Living Carroll 8. Date of Birth 1 2 - 13 - 1 908 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Davs Hours Maryland 214-01-1196 100 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 ☑ No MD Carroll Westminster 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 45 21157 Washington Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hardware Store Elementary/Secondary (0-12) College (1-4or 5+) Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Emge Margaret Chenoweth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2312 Coon Club Rd. Westminster, MD 21157 Judy Emge-niece 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lakeview Mem. Park 9-1-2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home PA 11 homas 254 E. Main St. Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or and a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 🗆 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Hinknown

**Physician** /Medical Examiner

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After this certificate

The law requires that the death certificate be execu-

Box 68760,

P.0.

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

the

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event

Baltimore, Maryland 21215-0036

Examine burial-trar attending physician Physician/Medical the for use a detached signed by the à cate has been signated by page 2 should b Completed Be ဂ္ funeral ( To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

23e. Did tobacco use contribute to the cause of death? 2₽No 3 Probably 4 Unknown 1 🗌 Yes

24a, Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

<ol><li>Place of Dea</li></ol>	ith (Check only one)		
Other: 4  Nursing H	ome 5 Residence	6 Sother (Specify)	bosseed
njury at /ork? □Yes 2□No	28d. Describe how inju		7400
е	28f. Location (Street a	and Number or Rural F	Route Number.

4  Homicide	determined	building, etc. (Specify)	o, iami, otroot, iactory, onice		City or Town, State)	Transel of Trafai House reams
29a. Certifier	Certifying Physic	cian: To the best of my know	edge, dean occurred at the time	e, date and place,	and due to the cause(s)	and manner as stated.
(Check only	2☐ Medical Examine	or. On the basis of examination	n and or investigation, in my opi	inion, death occurr	red at the time, date and	place, and due to the cause(s)

28b. Time of

Injury

1 Inpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day, Year)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

29c. License number

28c. jr

29d. Date signed (Month, Day, Year)

use of death (Item 23a) (Type, Print) 30. Name and address of person who completed

Po

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

		Plea	se Type or Pri					_	ole.		
		State of Maryland / Department of Health and Mental Hyg  1 - State Registrar  Certificate of Death  Registrar						eg. No. 2009 27889			
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Examin	er	4a. Facility Name (If not institution	_	)		r Location of Death		4c. County			
x*		7117 Martell			Dunda  If Under 1 Year		8. Date of Birth	Balti			
Funeral Director		5. Social Security Number 215-34-1136	6. Sex 7. A	ge (In yrs. last birthda 72 Yrs	Months Days				Birthplace (State or Foreign Country)  Maryland		
pui		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits		
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the M	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	/hat Country?		
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leath	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub:		ecify Yes or No-	14. Race	- American Indian,		
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ral", o	i by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates		1 □ Yes 2 🛣 No	Ѕреспу:		Specify:	White		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It of the death and the restrict of the content.		19a. Informant's Name/Relations Mike Mioduszewsł			ailing Address <i>(Str</i> eet 5 <b>Sunberry</b>						
s 1 a of Hei		20a. Method of Disposition		20b. Place of Dis	sposition (Name of crematory or other place	ce) Septer	noer 2,	20c. Location -	City or Town, State		
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th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		3 ☐ Ectopic pregnance	cv			e of delivery		
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		For State	State of	Marylan	•	rtment of l	Health and	-	giene Reg. No. 2	000	27200		
		1. Decedent's Name (First, Middle, Last)  Robert Jerone Cumberland							2. Date of Death 3. Time of D				
Physic /Medi			Cumberl		and Aug 2			26, 2009   2:10 A					
Exami	ner	4a. Facility Name (If not institution, give 222 East Barney St			or Location of Deat imore	:h	4c. County of Death N/A						
Funeral Director		5. Social Security Number  213–30–7670  6. Sex  7. Age (In yrs. last bird)  75				If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rth ay, Year) 9. Birthplace (State or Fore Country) Maryland				
and		Usual Residence of Decedent  10a, State 10b, County		10c, Cit	y, Town or Los	cation				1	0d. Inside City Limits		
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d be filed antal Hyg ed other	Be	17. Father's Name (First, Middle, Last) Charles R	. Cumber1	and	I	,	18. Mother's Na	me (First, Middle,	Maiden Surn	ame)			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	To.	19a. Informant's Name/Relationship (	Type. Print)	.ece)	1	-	t and Number or R	ural Route Numb			Code)		
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cate be executed cate be usecuted physician and the burial-transit	dical Ex	resulting in death) Last											
	Medi	IF FEMALE:											
The law requires that the death certificate has been signed by the attending rate has been signed by the attending progress and the standing progress and the standing progress and the standing progress as a second progr	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 🗆 Feta eant at time of c	Ideath 3	Ectopic pregnan Other <i>(sp</i> ec <i>ify)</i>	су			Date of deliv Month	ery Day Year		
Lires that the designed by the defacted by	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  1 ☐ Yes 2 🕱 No								he cause of death?			
ne faw requires to has been signinge 2 should be	Completed							24a. Was auto perfo		prior to co	opsy findings available ompletion of cause of		
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Physician: r this certificaral director, property	To B	examiner? 1 Yes 2 No		npatient 2		II 3 LI DOA		Home 5 Resi			fy)		
ing ing	ation:	27. Manner of Death  1     Natural 5  Pending 2  Accident investigation	1 '	of Injury h, Day, Year)	28b. Time of Injury	Wo	ıryat ırk? ⊒Yes 2.⊒No	28d. Describe	how injury occ	curred			
al or Atte after dea Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At hong, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To		ımber or Rur	al Route Number,		
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A	Medical C	29a. Certifier (Check only one)		asis of examina									
To the within To the	Me	29b. Signature and title of certifier	1	MAGE!		29c. Licer	se number		29d. Date sig				
		30. Name and address of person who	completed caus	e of death (Iten	n 23a) (Tvpe.		061711		Aiguist	٦6,	2009		
		KATHERINE THOSE	iter is	ands He	PKINS		EANS STA	LEET 689	BALTIM	NORE M			
Sta Regist		31. Date filed (Month, Day, Year)  SEP 0 1 20		egistrar's Signa		exhair							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death AU 61 Physician 1928 2009 Karon E. Compton /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ALTIMOR HUNES Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jul. 27, 1 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 1 F Months Yrs. 214-62-5835 1954 **Director** Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at MD Baltimore 1 ☐Yes 2 ☐ No **Funeral Director** Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4603 Linden Avenue 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify If Yes. Give Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural", The Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4or 5+) Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last)
Charles David Monroe, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda L. Everly ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Danny Compton - Husband 4603 Linden Avnue, Halethorpe, MD 21227

ce of Disposition (Name of Date 200. Location - City or Town, State Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Degrated of Disposition 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 8-31-2009 Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MOUMDNIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-tran Due to (or as a consequence of): Be Completed by Physician/Medical ned by the attending particles of the IF FEMALE 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has funeral director, page 2 autopsy or Attending Physician; The 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 □ Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 30. Name and address of PUSH APDEEP Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE, BALTIMORE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) HVUUS **Physician** HOKTE /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number)
NIVERS 174 OF MACHIANO HEDITAL COVIER 4c. County of Death Examiner N/A 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Nov. 29, 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign . 19<u>52</u> **Funeral** 1 M 2 □ F Days Months Hours Maryland 56 Director 213-64-0397 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show the Medical Executor must be notified at 1 □Yes 2√2 No Completed by Funeral Director MD Anne Arundel Linthicum 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or United States 21090 8 Mountain Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 1X Never Married 2 ☐ Married ٥ White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McDonald's Restuarant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked o William James Sylvester Choate, Sr. Edna L. Sloan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2783 Yarnall Road, Baltimore, MD 21227 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tratonce. Starr L. Brown - Sister 20b. Place of Disposition (Name of West's, arematory or other place) 20c. Location - City or Town, State Method of Disposition 1 D Burial 2 X Cremation 3 □ Removal from State Donation 5 Other (Specify) 9-2-2009 Odenton, Maryland rematorv Funeral Service Lice 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arkutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Phours after death.
neral Director: After ty filled in by the funera 1 Natural 5 Pending 5:00 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 P.O. Division of Vital Records,

3altimore, Maryland 21215-0036

within 24 hours a To the Funeral D Hospital of the Hours a the

> State Registrar

29c. License number d title of certifier

to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

ame and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH CREEKE

(Check only one)

29b. Signature

_			1 - For State Registrar	State of Maryla		rtificate of			Reg. No.	UUS	1109
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	Year	3. Time of Death
	/Medic		Gladys	Joy	Caug	hy		Augus		2009	4:00 A M
	Examir	er	4a. Facility Name (If not institution, give				or Location of Death			ty of Death	
a regel			Stella Maris Hos			Tir If Under 1 Year	monium I If Under 24 Hrs.	T		timore	
Ĺ	Funeral Director		5. Social Security Number 6. Social Security Number 1 219-40-1820 Usual Residence of Decedent	0 Age (In yi	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Biri (Month, Da April	th ay, Yea <i>r)</i> 14,1943	Coun	lace (State or Foreigr try) yland
	land ow		10a. State 10b. County	10c. 6	City, Town or Lo	cation				10	0d. Inside City Limits
	Mary f she	Ö	M 1 1 - 51	, ,		D - 1	1 + 1 0	2 4			1 ⊈Yes 2 □ No
	r 28a	Director	Maryland Ni 10e. Street and Number	A		10f. Zip Code	ltimore C	ILY	10g. Citizen of	What Coun	try?
	3a o	<u></u>	6701 Duluth Aver	1110			21222		Unite	d Stat	tes
	deatl	ner	11. Marital Status	12. Was Decedent Ever in	U.S. 13.1	Was Decedent of F	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No		ce - Americ	an Indian,
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modicel Expraigner reast be recified at once.	Completed by Funeral	1 ☐ Never Married 2 【X Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1		1 ⊡Yes 2y⊡No		o Rican, etc.)	Spec	ack, White, e	nite
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of work	kina	16b. Kind of I	Business/Ind	lustry
21	ithin ne. han "	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)	9			
121	led w lygie her tl	흥	12 Years		Но	memaker		(Fig. 4 - 4 4) -1 -21 -	Own Ho		
anc	be fi	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			те)	
Maryland	d Me nark natic	은	William Moltz	- a - Unahand	405 14-75			elia Kro			0.40
Ma	12 sh th an 7 is r traur		19a. Informant's Name/Relationship (7 Mr. Howard J. Caug			ng Address (Street Duluth A	and Number or Ru. Avo Ra1	timore,			Code) L222
	1 and Healt em 2 ther		20a. Method of Disposition					Date	20c. Location		
٥	nt of nt of the it		1 ☐ Burial 2XXCremation 3 ☐	Hemoval from State 1	-	sition (Name of natory or other place					
Baltimore,	it. Partime		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen.				Corp; 8/3			•	ryland
Ba	Deparenti Impo any Ir once		21. Signature of Funerar Service Licen.	see	24	Duda-Rucl	ess of Facility K Funeral	Home of	f Dunda	lk, Ir	nc.
			23a Part 1 Enter the disease of firms	digations that caused the de	ath. Do not ont	7922 Wise	e Ave. Di	undalk,	Maryla	nd 21	Approximate
			23a. Part 1. Enter the disease of comp shock, or heart failure ist only of					or respiratory a	11031,		Interval Between Onset and Death
	hysicían /Medical		disease or condition resulting in death)	a. END STAGE		AILURE D	ISEASE				
	Examiner			Due to (or as a conse	equence of):						
		ē	Sequentially list conditions,	b. Due to for as a const	e uence of						
S	uted I Insit	ᆵ	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury								
20	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a conse	equence of):						-
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68760,	tificate ig physi as the k	<b>Nedical</b>		u.							200
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnand Other (specify)	су			ate of delive fonth	ery Day Year
σ.	that the led by detac		Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of death?
ds,	uires sign d be	d by		•	Ū	, ,		1 🗆 `	Yes 2 No	3□ Prob	ably 4 🗌 Unknown
Records,	w requires s been sign should be	Completed		<del>1. · · · · · · · · · · · · · · · · · · ·</del>				04-144-			Gooding on a socilable
Re	The law cate has page 2 s	m ld						24a. Was autor		prior to cor death?	psy findings available npletion of cause of
-								1 □ Yes	2 <b>X</b> No	1 ☐ Yes	2 No
Vital	9. Se	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dear				
of	Phys r this ral di	To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2  28a. Date of Injury	28b. Time of	11 3 LJ DUA	4 LI Nursing H	ome 5 ☐ Resident Secribe I			HOSPICE
Division	Attending Fr death. ector: After	tjor	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	Injury	Wor	k? ]Yes 2 □ No	Lou. Dodding i	non injury cooc		
S	or Attendate death after death Director:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, str		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28f. Location (S	Street and Nun	ber or Rum	I Route Number,
S	after Direct	Certification:	4 ☐ Homicide determined	building, etc. '(Spe	cify)	,,,		City or Tov		700, 0, 7,44,4	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or viithin 24 hours after To the Funeral Director completely filled in b	Medical C	29a. Certifier  (Check only one X Nurse Pract	ysician: To the best of my k iner: On the basis of exami - Tand papener stated.	nowledge, death nation and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and place	manner as s a, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and atle of certifier			29c. Licens	se number		29d. Date sign	ed (Month, I	Day, Year)
			* ALLANO	IRNA		RI	49792		272	1200	9
	^		30. Name ang/address of person who co	completed cause of death (It	em 23a) (Type.	Print)	11.1-		0100	1000	1
	10		JACKIE JONES, CRN				TIMONIUM.	MD 210	193		
	Sta	te	31. Date filed (Month, Day, Year)	32. Degistrar's Sig	nature	The state of the s	UII				
	Registr	ar	SEP 0 1 20	09 Dun	A. 40	arked					

DHMH 17 Rev 1/2001

4:00 a.m.

AUGUST 28, 2009

GLADYS CAUGHY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Davis 1:27PM OUCH 2009 lar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 7/28/1927 1 □ M 2 🔀 F 82 240-46-5524 Alabama Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a, State 10c, City, Town or Location 28a-f show aţ 1 X Yes 2 □ No Director must be notified MI Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò 21218 U.S.A. 23a 731 Bartlett Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 Yes 2 No þ If Yes, Give Specify Specify: White 3 XWidowed 4 Divorced Year or Dates Completed er than "natur the Medical I 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Education 12 Teacher permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Owen Couch Lela Grey ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dana Couch-Davis/ Son Bartlett Avenue, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 又 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 8/31/2009 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) SUDS Due o (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreese or nary that initiated events Examine Due to (or as a consequence of) physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 2 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury this 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 ☐ Accident Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: A completely filled in by the f

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hernang Adam 2

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) SEP 012

29b. Signature and title of certifie

29a. Certifier

(check only

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#4a, perPHYS, #10e, 19b, perFH, C895, 9710/09, WS State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If cot institution give street and number) 4b. City, Town, or Location of Death Examiner 1912 Cornbridge Lane Baltimore Monkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye NOV . 14, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Year 1 □ M 2 □ XF 1924 Maryland 84 220-12-5252 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 X No Baltimore Monkton Directo MD 10e. Street and Number Corbridge 10g. Citizen of What Country? 10f. Zip Code USA Cornbridge Lane 21111 1912 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify. white Specify: ۾ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Black & Decker Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth North Harry C. Oliver ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1912 Cornbridge Lane-Monkton, Maryland 21111 Ronald Causey-son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens
22. Name and Address of Facility 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sept.3,2009|Timonium, Maryland 21. Signature of Funeral Service Licensee 16924 York Road Evans Funeral C and Cremation Chapel Servi Monkton, MD 21111 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final arction 40 Caro **Physician** disease or condition resulting in death) /Medical Due to ar as a consequence of): Examiner Sequentially list conditions, than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diss to for as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after dec. eral Director: A\* v filled in by the 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and adds GREGORY A. COMPTON, MT Baltimore 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ra 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1:00 A M 2009 DEISROTH August 31, ERMA JANE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 500 Barksdale Road Joppatowne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 24, 1932 Director Pennsylvania 166-26-0045 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Maritan Experiment 2000. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Directo Joppatowne Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21085 USA 500 Barksdale Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Child Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Della Jane Folckemer William R. Bracken ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 500 Barksdale Road, Joppatowne, Maryland Charles Deisroth / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdn. 9/4/2009 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER **Physician** MONTH disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed P.O. Box 68760, Co Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 3 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has triector, page 2 s Was an autopsy performed? 1 ☐ Yes 2 □ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Other: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural 1 ☐Yes 2 ☐ No death. 2 Accident after death | Director: / d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 069 now 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI Edgewood Way

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

strar's Signature

32. Red

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			For State Registrar	State of Mar		rtificate			-	Reg. No.	2000	07007
r	Dharatala		Decedent's Name (First, Middle, L.)	ast)					2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		CHARLES JOSEPH					i ( B	AUGUST	30,	2009	12:40 P
No.	Examin	er	4a. Facility Name (If not institution, g				own, or Locat st_Hil				County of Deat [arford	n
	Funeral		1204 Teaford Ro 5. Social Security Number 6.	Sex 7. Age (	In yrs. last birthday	) If Under 1	Year If Un Days Hou	nder 24 Hrs.	8. Date of Bir (Month, Da	rth	9. Birt	hplace (State or Foreign untry)
	Director		213-36-5549 Usual Residence of Decedent	1 <b>∑</b> M 2□F	71 Yrs.				Apr. 3			ryland
	yland low at		10a. State 10b. County	1	0c. City, Town or I	ocation						10d. Inside City Limits
	e Mar 3a-f sh tiffed	ctor	Maryland Harfo	rd	Forest	Hill						1 ☐ Yes 2 X No
	with th a or 24 be no	Directo	10e. Street and Number			10f. Zip C				10g. Citiz	en of What Co	untry?
	death ms 23	Funeral	1204 Teaford R	12. Was Decedent Eve	er in U.S. 13			o Origin? (Sp	pecify Yes or No Rican, etc.)		4. Race - Ame	
٥	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Medical Examiner must be notified at		1 Never Married 2 Married	If Yes, Give		1 ☐ Yes 2			o Alcan, etc.)		Black, White Specify:	
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<u>.</u>	nin 72  In "na Medic	plete	(Specify only highest of Elementary/Secondary (0-12)	rade completed)  College (1-4or 5+)	(Giv	e kind of work DO NOT use	done during retired)	most of worl	king			
7	ed with ygiene ner tha ner the	Completed		1	Al	arm Tec			- /First 861 date		ecurity	7
and	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Memlar Hygiene at the first and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name ( <i>First, Middle, La.</i> Joseph Clement						ne (First, Middle rine Lor		,	er
ar y	should and Me mark umatic	To	19a. Informant's Name/Relationship		19b. Mai	ling Address (\$			ral Route Numb			
, Ma	es 1 and 2 of Health a f item 27 is r other tra		Mary Carol DiP	aula / Wife				d, For				1, 21050
more	iges 1 nt of Hi if iter or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place of Disposer			0.72	Date		cation - City or	
Saltlin	permit. Pages 1 Department of h Important: If ite any injury or of once.		4 □ Donation 5 □ Other (Special Service Lice		St. John	'S Catr 22. Name and			2009 Comas I		des, Ma	
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Kesp	intury 1	ailwe						
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200	death certificate be e attending physicia d for use as the bun	Physician/Medical	IF FEMALE:			-						
X Q Q	eath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pre				2	3d. Date of de Month	livery Day Year
j.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	ne or death c	□ Other (spec						
က် ၂	e law requires that the death certificate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	by PI	Part II. Other significant conditions	s contributing to death but	not resulting in the	underlying cau	use given in F	Part I.				o the cause of death?
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_	10 -		25. Was case referred to medical				26. 1	Place of Dea	1□ Yes	2 No	1 □ Yes	5 2 <b>4</b> 0
0 Z	Physiclan: this certific	To Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpati		Other: 4[		lome 5 Aes	_	i □Other (Spe	ecify)
	ding Phys		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	(ear) 28b. Time Injury	of 28	c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury	occurred /	
UIVISION	Attenc death ector: by the	ficat	2 Accident investigat 3 Suicide 6 Could not	be 28e. Place of injury	- At home, farm,			2010	28f. Location	(Street and	d Number or R	ural Route Number,
É	tai or	Certification:	4   Hornicide	building, etc.						ówn, State)		
	To the Hospital or Attending Physician: within 24 hours after deals.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical Ex	Physician: To the best of caminer: On the basis of e	xamination and/or	investigation, i	in my opinior	n, death occu	urred at the time	e, date and	place, and du	e to the cause(s)
	o the vithin 2 or the omple	Med	29b. Signature and title of certifier	and manner state	ed	29c.	License num	ber		29d. Date	e signed <i>(Mon</i>	th, Day, Year)
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	15		30. Name and address of person when D. Rotus to	no completed cause of dea	th (Item 23a) (Typ	e, Print)	N. W.	1k57.	Balta	+C,	MS 21	287
	Sta Registr		31. Date filed (Month, Day, Year)	1 2009 32. Registrar	s Signature	garke						

			For State Registrar		artment of Health and rtificate of Death		erie eg. No. 2 1 1 9	27202
			Decedent's Name (First, Middle, Last)		<u>.</u>	2. Date of Death Month	1	3. Time of Death
	Physicia /Medic		Florence Virgi		1.	August	29, 2009 ar	2:10 Ам
	Examin	er	4a. Facility Name (If not institution, give street a Stella Maris Hosp	· ·	4b. City, Town, or Location of Deal Timonium	h	4c. County of Death  Baltimore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs	8. Date of Birth	9. Birthpla	ce (State or Foreign
	Director		217-14-5730 1□M 2	85 Yrs.	Months Days Hours Min	04/08/19	24 Mary	
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		100	d. Inside City Limits
	e Mari	Director	MD	Baltir	nore			1X Yes 2 No
	with th	Dire	10e. Street and Number		10f. Zip Code 21224	10	Og. Citizen of What Country  U.S. A	y?
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215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Misideal Examination in the Leading at	þ	1 Never Married 2 Married 1 If Ye	lYes 2 <b>X</b> 1No	If Yes, specify Cuban, Mexican, Puer 1 □ Yes <b>Ж</b> □ No Specify:	to Rican, etc.)	Black, White, etc	
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	e filed al Hyg I other vent, I	Be C	17. Father's Name (First, Middle, Lest)	_		me (First, Middle, M	faiden Surname)	
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, Maryland	1 and 2 sh Health and tem 27 is π	1 3	19a. Informant's Name/Relationship (Type. Prin Linda Eigner/ Dau	ghter 3514	ng Address (Street and Number or Fi Esther Place,	Baltimore	e, MD 21224	
Baltimore,	permit. Pages 1 al Department of Hee Important; If Item any Injury or othe once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	Parkwoo	od Cemetery 08/	31/09	Parkville, MD	
Bal	permil Depar Impor any Ir	9 19	21. Signature of Funeral Service Licensee	NOUND E	Name and Address of Facility Vans Funeral ( 800 Harford Ro	hapel & Ci l. Parkvil	remation Serv: le, MD 21234	ices
		2. 12	27a. fart1. Enter the disease, or complications shock, or heart failure. List only one caus immediate Cause (Final	that caused the death. Do not en e on each line.	ter the mode of dying, such as cardia	c or respiratory arre		Approximate nterval Between Onset and Death
	Physician / /Medical		dise se or condition resulting in death)	RONIC OBSTRUCTIV	E PULMONARY DISE	ASE		
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O. Box	The law requires that the death certificate be executed ate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			y Day Year
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Vital Records,	w require been si should b					1 ☐ Ye	s 2 No 3 Proba	bly 4 Unknown
3ec	e law has b	Completed		·		24a. Was an autopsy perform	v prior to com	sy findings available pletion of cause of
E	lan: The I rtificate ha tor, page	e Co	25. Was case referred to medical		OC Place of Do	1 □ Yes 2	XINo 1 ☐ Yes 2	! □No
f Vi	yslc iis ce direc	To B	examiner? 1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:		nce 6X Other (Specify)	HOSPICE
	ng Te	ion:	1 Natural 5 ☐ Pending	Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	28d. Describe hor	w injury occurred	
Division	at at a	ficat	2 Accident investigation 3 Suicide 6 Could not be	Place of Injury - At home, farm, sti	M 1 ☐ Yes 2 ☐ No reet, factory, office	28f. Location (Str	reet and Number or Rural	Route Number.
Ο̈́	ital or / rs after al Dire led in b	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town,	, State)	,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical	29a. Certifier  (Check only one X Nurse Practition	n the basis of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manner as sta ate and place, and due to t	ated. the cause(s)
	To t To t	Ž	29b. Signature and title of certifie	en a P	29c. License number	29	9d. Date signed (Month, D.	ay, Year)
			30. Name and addry's of person who complete	V( / V/ d cause of death (Item 23a) (Type	Print)		0131160	/
_		r s	JACKIE JONES, CRNP	2300 DULANEY VAI		M, MD 210	93	11
	Sta Registr		31 Date filed (Month Day Yeer)	32. Registrar's Signature				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 2009

3. Time of Death

208

10d. Inside City Limits

XX es 2 No

Md 21217

years

Year

Approximate Interval Between Onset and Death

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【No

9. Birthplace (State or Foreign Country) unk.

Black, White, etc. African

Specify: American

NA

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1. Decedent's Name (First, Middle, Last) **Physician** August Jocelyn Everett /Medical 201 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b City, Town, or Location of Death etimore pita De 3. Date of Birth (Month, Day, Year) 09-27-69 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Social Security Number 1□M 2X F Months Min 217-84-4926 39 Director Usual Residence of Decedent 10h County 10c. City. Town or Location 10a State ed other than "natural", or items 23a or 28a-f shot event, the Wedley Examination of the Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street USA Funeral 21201 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Unk. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Unk. NA unk 18. Mother's Name (First, Middle, Maiden Surname) Unk. 17. Father's Name (First, Middle, Last) Unk. Be ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 Terry Sullivan-Guardian North Calvert Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If its any Injury or o 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State Zion Cem. 08-29-09 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 4105 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ling physician and 9 as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an has be 2 s this certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number D439386 05

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 8.27.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R 4405 821 N. Balk nore 21201 31. Date filed (Month, Day, Year) **ORIGINAL** 

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Delores Erhardt May 30, August 2009 12:20A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1772 Brookview Road Dundalk Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 1 □ M 2X□ F 217-40-3803 65 Director March 19,1944 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show The Medical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland | Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1772 Brookview Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 📉 No Specify: ģ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Domestic Engineer Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fit If Health and Mental H Item 27 Is marked otl William Icenroad May Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Erhardt Husband permit. Pages 1 an Department of Heah Important: If item 2: any Injury or other 8 1772 Brookview Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2, 2009 21. Signature of Fundral Service Licenses Conneily Funeral Home Of Dundalk, P.A. nthone 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. one of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lind only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatac colon concor years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): Box 68760, physician the buria Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Breast concer Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Discase 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Non-small luco canco 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA or Attending Patter death.

Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L Hospital CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) pronos , MD

Division of Vital Records,

31. Date filed (Month, .Day, Year) State Registrar

DHMH 17 Rev 1/2001

1. Prowier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Balterac, MD

			for State Registrar	State of Mar		epartment of F Certificate of I			giené- U Reg. No.	00	1701
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	pu: N		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	r Location				1	0d. Inside City Limits
	// Anyla	ō		imore	Dund					'	1 Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	try?
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	withi com	Me	29b. Signature and title of certifier		ww	29c. Licens	e number	7	29d. Date sign	med (Month,	Day, Year) 4,2009
a	X1		30. Name and address of person v	who completed cause of deat	th (Item 23a) (Ty	pe, Print)	shed R	altimo	- un	21:	2,36
	Sta Registr		31. Date filed (Month, Day, Year) <b>SEP 0 1 200</b>	32. Registrar's	Signature			, - , , , , - , - ,	- (		
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			State of Maryland / Department of Health and Months    1 - State		giene Reg. No.	9	27902
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	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of	Death	
			Baltimore VA Medical Center Baltimore		c 9400		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Day	h v, Year)	). Birthp	place (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			1	Od. Inside City Limits
	Maryl f sho	o	Maryland Baltimore City Baltimore				1 X Yes 2 □ No
	the l	Directo	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Cour	ntry?
	as or		2707 Northshire Drive 21230		Jnited S		
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อ์	of Hea item		20a. Method of Disposition 20b. Place of Disposition (Name of Compton of Comp	ate 29	20c. Location - C		own, State
Ĕ	Pages nent of I ent: If it ury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  August Metro Crematory, Inc., 200	59~'	Baltimore	≥, M	Maryland
Baltimore,	permit. Pages 1 Department of H Importent: If itel any injury or ott		21. Signature of Funeral Service Licensee  Alice Iser  22. Name and Address of Facility Cremation Society of S	f Maryl	and, Inc	ond	21228
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5	s afte	Certification;	4 Homicide determined building, etc. (Specify)	City or Tow	m, State)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the o	cause(s) and mand date and place, an	er as s d due t	tated. o the cause(s)
	Nithin Fo the	Me	29b. Signature and title of cartifier 29c. License number		29d. Date signed (	Month,	Day, Year)
			Nelahad MD P-23445		08/2	7/0	9
	6+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Q. 1	hima	MN	21201
	Sta		31. Date filed (Month, Day, Year)  22. Registrar's Signature	Dal	, דייטוייי	rw	oci av i
	Registr	ar	SEP 0 1 2009 Server B. Jane				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month George Linwood Foy 7009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltmore Sinai Hospital Baltimore, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours M 2 □ F 55 Director <u> 218-64-1318</u> 1954 Maryland June 6. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 21215 10e. Street and Number 3901 Wabash Ave Apt. 1B Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐Yes 2X No Specify: ģ If Yes, Give 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Victory Packing Co. Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Operater 6th grade 18. Mother's Name *(First, Middle, Maiden Surname)* Georgia Blandburge 17. Father's Name (First, Middle, Last) James Foy 19a. Informant's Name/Relationship (Type. Print)
Deborah Jones/ Sister 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zio Code) 'Snug Lagoon Ct. Middle River, MD 21220 permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 反 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/09 Lansdowne, Maryland Mt. Zion Cemetery : 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 Harr Approximate Interval Between Onset and Death 23a. Part I. Enter the Life ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Isilure. List only one cause on each line. Immediate Cause (Final **Physician** Intra Cranial Hemorrhage day disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 100 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 29, 2009

State Registrar

YOU?

MOSPITAL OF

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MIRTINKUBIN

31. Date filed (Month, Day, Year)

			for State Registrar	State of Maryland	Department of Health and Certificate of Death	, ,	iene <sub>g. No.</sub> 2009 2790
200	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) Adrian M.	Garris		2. Date of Death Month AUGUST	Day 2009 0045M
	Examin Funeral Director	er	Dau-11-1236	tospice	birthday) If Under 1 Year If Under 24 F Months Days Hours M	Wn	4c. County of Death  Baltimore  9. Birthplace (State or Foreign Country)  Year,  1970 Maryland
	the Maryland 28a-f show	ector	Usual Residence of Decedent  10a. State 10b. County 10c. Street and Number	10c. City, To	own or Location altimore		10d. Inside City Limits 11 Yes 2 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evanting rough by natified an once.	<b>Funeral Director</b>	1707 Clifty	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NNo	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.
21215-0036	ithin 72 hours in ne. han "natural",	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)	If Yes, Give" Year or Dates:  ation completed)  College (1-4or 5+)	1 ☐ Yes 2 ☒ No Specify:  6a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work done during most of work during most of work done during most of work	vorking	6b. Kind of Business/Industry
Maryland 21	ould be filed w d Mental Hygie narked other ti natic event, tr	To Be Col	17. Father's Name (First, Middle, Last)  Jasper Ga	rris	Glor	lame (First, Middle, N	n Finch
ore, Mar	ges 1 and 2 sh tt of Health and If Item 27 is m or other traum		19a. Informa 't's Name/Relationship (Ty)  NS. Mary Find  20a. Method of Disposition  1 Burial 2 10 Cremation 3 Re	20b. Place cemeral from State	9b. Mailing Address (Street and Number or 707 CIFTVIEW of Disposition (Name of terry, crematory or other place)	Ave. P	City or Town, State, Zip Code)  Oc. Location - City or Town, State
Baltimore,	permit. Pa Departmen Important: any injury once.	1 10	4 □ Donation ' 5 □ Other (Specify)  21. Signature of Funeral Service License	Russ	22. Name and Address of Fullity Joseph L. Russ 2222 W. North	Funeral Typ. Ba	Balto, Md. Home, P.A. Ito, Md. 21216
	Physician /Medical	E US	23a. Party Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	eations that caused the death. Decause on each line.		fiac or respiratory arre	st, Approximate Interval Between Onset and Death
	ficate be executed  I physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence			
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ıtal Rec	sician: The law certificate has trector, page 2 sl	Se Completed	25. Was case referred to medical		26. Place of D	24a. Was an autopsy perform 1 Yes 2	prior to completion of cause of death?  ☑No 1 □ Yes 2 □ No
Division of Vital Records,	his h	ation: To B	1 Yes 2 No Ho  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ ER/ 28a. Date of Injury (Month, Day, Year) 28b	Outpatient 3 DOA Other: 4 Nursing  1. Time of Injury at Work?  M 1 Yes 2 No	g Home 5 ☐ Resider 28d. Describe how	
DIVIS	pital or Atte ours after de eral Directo filled in by th	Certification:	3 Suicide 4 Homicide  29a. Certifier  1 Certifying Phys	28e. Place of Injury - At home, building, etc. (Specify)		City or Town,	
:	To the Hos within 24 hd To the Fun completely	Medical	(Check only one)  29b. Signature and title of certifier	er: On the basis of examination and manner stated.	Ige, death occurred at the time, date and pland/or investigation, in my opinion, death or	ace, and due to the ca courred at the time, da	d. Date signed (Month, Day, Year)
			30. Name and address of person who cor	npleted cause of death (Item 23a	and/or investigation, in my opinion, death of 29c. License number 50057465  a) (Type, Print) 54176 2000	, Reisterst	DWN, MD. 21136
	Stat Registra	~	31. Date filed (Month, Day, Year) SEP 0 1 2009	32. Registrar's Signature	backer	-	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7 & 8 per HF G895 9/3/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Karna Elizabeth Gilday 30 2009 7:10 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1919 9. Birthplace (State or Foreign Country) NY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 K 064-22-4242 **Director** <del>95</del> 90 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examiner is set by positived at 1 Yes 2 No Director MD **Baltimore** Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2300 Dulaney Valley Rd. 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify <u>გ</u> Specify: white 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales n/a Retail Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Benson Elizabeth Anderson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith Chilcoat/daughter 14262 Trap Pond Rd., Laurel, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 8/31/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Furnity Service Licen Michael Flat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause unleach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** nemen emer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jacobs of Light) that initiated events Examine Due to (or as a consequence of) use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) detached 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, à 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 st 24a. Was an autopsy performe this certificate 1 ☐Yes 2 No 2 No 1 ☐Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No illed in by the fu after death 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

ERNESTINE WRIGHT, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7:10

2009

AUGUST 30,

GILDAY

KARNA

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

1 - State Registra 1. Decedent's

BRIAN 31. Date filed (Month, Day, Year)

**Physician** /Medical

Examiner

Be Completed by Funeral Director

ဥ

Examiner

Medical Certification: To Be Completed by Physician/Medical

After this certificate has funeral director, page 2

**Funeral** 

Director

State Registrar			Cer	tificate	e of D	eath			Reg.	No.	F 17	17	1 4.13	25 25 11
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Genesis Elder					timo						IA			
210-94-4/31	7. А <u>г</u>	ge (In yrs. last b 31	Yrs.	If Under Months	Days Days	Hours M		8. Date of 0.440 <i>nth</i>	Birth Bay, Y	198) 	9.	Birthplac Country		or Foreign
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Elementary/Secondary (0-12) 9th Grade	College (1-4or	5+) I	Labo	OO NOT us	se retired)	ing most of v	working	<i>y</i>	Vε	ario	ous	job	s	
. Father's Name <i>(First, Middle, Last)</i> Carl Goin	S				1	8. Mother's N Char				den Suri hns				
9a. Informant's Name/Relationship (Ty) Charlene Johns						nd Number or talou							MD	2121
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Signature of Funeral Service License	ee		22.	Name and	d Address	of Facility	Wi	lie	Fur	nera	a1 E	Iome	P.	Α.
Alexandra !	Orango		6.3											
3a. Part 1. Enter the disease, or compli shock, or heart failure, List only or	cations that cause	d the death. Do	63 o not ente			Lmor S such as card					nore	Aı	pproxima terval Be	etween
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State Registrar

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C-WALLACE MW 9005 KILBRIDE RD BATIMOLE MW 2423,

ay, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month + **Physician** 200 03:00 P M Margaret R Gregory /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Bultimore Baltimore City 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year, 03/05/1933 9. Birthplace (State or Foreign **Funeral** 1□ M 2ቖ F Months Days Hours Min. 76 Mary Tand Director 213-30-9544 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director MD Baltimore Halethorpe 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 1961 Brady Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗓 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No 2 Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental August J. Oldenburg ပ Mabel Rose Shulz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other trae Vicki Starin / daughter 1961 Brady Ave Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 08/29/2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundry Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** ardiomyapath disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner omflete Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Horgan and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autonsy certificate perform Division of Vital 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1∐Yes 2∭ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a MC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type Print) iston Ave. Baltimore MD 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

LE6024

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** F M 2009 /Medical 4c. County Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner mar ta 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign Security Number **Funeral** 6. Sex 1 □ M 2 CF Months Days Hours Min. 6 and Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director more 10f. Zip Code 10g. Citizen of What Country? 10e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 MWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SMame (First, Middle, Last), 18. Mother's Name (First, Middle, Maiden Be P 19a Informant's Name/Relationship 19b. Mailing Address (Street and Number of ural Route Number Town, State, Zip Code (Twoe, Print) tiG. 500 500 18 permit. Pages 1 and Department of Healt Important: If Item 27 any injury or other 1 once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of gemetyry, crematory or other) **D**ate 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Faciliti tome N. Fulton the Md 23a. Part / Enter the discrete, or complications that caused the death. shock, or heart failure. List only one cause on each line. Imm-diate / ause (Final discrete ric condition re-ulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death days **Physician** 05 /Medical Due to (or as a connequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes P.O. 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 X No 1 ☐ Yes 2 **54**00 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 15 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ust 29,2009 News D0052583

State Registrar

DHMH 17 Rev 1/2001

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Registrar's Signature

Saltimore, Mo

21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mildred M. Hurd 8:25 PM August 297 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore Charlestown Retirement If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In vrs. last birthday Date of Birth (Month, Day, Days Hours Year. 1 □ M 2 🕶 F 215-01-7372 96 Aug. 22, 1913 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 ☐ Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 709 Maiden Choice Lame 21228 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Standard Oil College (1-4or 5+) Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Melgard Margery Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5439 Princess Drive, Baltimore, MD 21237 Margaret Hurd/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 09/01/09 Parkville, MD Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evars Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmr diate Cause (Final ise se or condition resulting in death) Phaumonic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Light) that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

be executed

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A

filled in by the

death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ral", or Items 23a or 28a-f shov Examiner must be notified at

Director

by Funeral

Completed

Be

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Examiner

Physician/Medical

Completed

Be

Certification: To

Medical

(Check only

30. Name and a

29b. Signature and title of certifier

dress of person who completed

reporter MD

with the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner

Baltimore, Maryland 21215-0036

and attending physician the as 1 nse for ed by the a detached i signed by page 2 certificate After this

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 20 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

Maiden Choice Ln Cataroville

29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 1.58 PM JESSE HAIRSTON JAMES AUGUST 28 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MD 21215 BELNEDERE 2401 W. BALTIMORE SINAI HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 26,1945 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min. **X**X<sup>M</sup> 2□ F MD **Director** 213-44-7932 Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at MD N/A Baltimore XX Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2812 Ruscombe Lane 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 🗙 o Specify: Specify: Black <u>ک</u> 3 ☐ Widowed 4 💢 vivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator McCormick Spice 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvin Smith June Marie Meyers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danelle Jones (Niece) 2812 Ruscombe Lane Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Atlantic Crematory 9/5/09 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Lemmon Funeral Home of Dulaney Valley, Inc. 10 West Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) ARDS **Physician** /Medical Due to (or as a consequence of): Examiner Chronic respiratory Sequentially list conditions, if any first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner acute on chronic burial-trar the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 ☐ Pending investigation Naturai 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box  $68760^{ imes}$ filled in by the funeral director. after death. To the Hospital within 24 hours at To the Funeral D

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined

4 Homicide 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier,

29d. Date signed (Month, Day, Year)

21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 🔥 🖒 🙌

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State

Registrar

2434 W. BELVEDERE AND BALTIMORE MA LEVINDALE 31. Date filed (Month, Day, Year) 32. Registra's Signature

parke

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 3 Pay 2009 12:10Am Ruby Christine Hudson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Genesis Eldercare Brooklyn Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 13, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 TA **Funeral** 1□ M 210 F 77 Yrs VA 231-34-2376 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f shorthe Medical Examiner must be neithed at Director 1 ☐ Yes 2X No Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 21225 U.S.A. Hammonds Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Retail permit, Pages 1 and 2 should be filed v Department of Heatth and Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Nora White Roy White ပ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Park Avenue, Halethorpe, Maryland 21227 Mrs. Janet L. Spitzler / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 24 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 09/02/09 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Mol357 Singleton Funeral & Cremation Services, P.A. ark Vanu 23a. Part1. Encr the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have allure. List only one cause on each line. Immediate Cause (Final **Physician** EMEN disease or condition /Medicai resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) the 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 I Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and Ittle of certifie 29c. License number 29d. Date signed (Month, Day, Year) MI 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oakwood Road Glen Burnie MD21061 1845 avanar 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2009 :57 a August Lindsev Trvin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept. 24,1960 Min 1 X M 2 □ F Days Hours 215-88-2996 Taïwan Director 48 Yrs Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ▼ No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21044 6501 Folded Leaf Square 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🔀 No Specify. Specify: White Completed 3 Widówed 4 Divorced Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Sales Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Tipton Harold Robert Irvin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21044 6501 Folded Leaf Square, Columbia, Maryland Amy S. Irvin/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State August<sup>ate</sup> 29. 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Ligensee Amada Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ 19 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to inmedicause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the attending physician and Due to (or as a consequence of) resulting in death) Last by Physician/Medical requires that the death certificate be IF FEMALE signed by the attendin d be detached for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Records, Completed 1 Yes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 2 Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 100 Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred the Hospital or Attending work? 1 ☐ Yes 2 ☐ No Matural 5 Pending ☐ Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 only one Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, condect lase of death (Item 23a) (Type, Print) 31 Date filed (Month: Day Year . Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 31, 1:10 A. Jenkins August Edith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Northhampton Manor | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, May 21, 19 Birthplace (State or Foreign Country)
 VA 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 € XF 98 Yrs Director 215-36-5777 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Carrol1 Mt. Airy 1 Yes 2 No MD Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code with United States 21771 6603 Runkles Road death Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 honen of Health and Mental Hygiene. ant: if item 27 is marked other than "nati (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Housewife own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sarah Tevault Carlisle Elick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Airy, MD 21771 dau hter 6603 Runkles Road Wilma Hallaren other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit. Page Department of important; if any injury or once. injury or Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 alm Henter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, x, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1 sho Immediate Cause (Final **Physician** Congestive heart disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes pertension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? sate has t page 2 s 2 M No certificate 1 Yes 1 Tyes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 27. Manner of Death
1 Natural
2 \( \text{Accident} \)
3 \( \text{Suice} \) Hospital: Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation after death. 1 Yes 2 No the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier 29c. License number Hug 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21702 Johnson Dr. Hiren Shah MD lhomas 31. Date filed (Month, Day, Year) Registrar's Signature State SEP 0 1 2009 Registrar Barka

		For State	State of Maryl		epartment of I Certificate of			0.1	0.00	27011
		Registrar  1. Decedent's Name (First, Middle, La.	st)		Jei lilicate of	Death	2. Date of De		JUJ	3. Time of Death
Physicia		Grace O. Johnson	,				Month	+ 30	Year	650pm
/Medica Examine		4a. Facility Name (If not institution, giv	<del></del>		4b. City, Town, o	or Location of Death			unfy of Death	
		Seasons Hospice			Randa1			Ba1	timore	
Funeral		5. Social Security Number 6. S	□ M 2 <b>K</b> JF	yrs. last birth Y	rs. If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	a <i>y</i> , Yea <i>r)</i>	Cour	
Director		213-26-4590 Usual Residence of Decedent	85	•	10.		7/18	3/24	Vir	rginia
yland now		10a. State 10b. County	100	. City, Town	or Location				1	10d. Inside City Limits
a-fs	cto	MD n/a	a	Bal:	timore					1 X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
s 23a	ra	4231 Towanda Ave			212				USA	1-4
0 0	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	etc.
2 hour		15. Decedent's Ed	ducation	16a. i	Decedent's Usual Occup	pation		16b. Kind o	of Business/In-	Slack Industry
hin 7%	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work done life. DO NOT use retire	during most of work d)	ing			
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be file tal Hy d oth eveni		17. Father's Name (First, Middle, Last,	)			18. Mother's Nam	•		name)	
ould I Mer narke	၉	Norman Hendrick					e Linds			0.13
d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (			Mailing Address (Street					
1 and Heal tern 2	-	Carolyn O. Redmo			325 Westrid Disposition (Name of crematory or other pla	ge Rd. Ba	Ltimore Date	, Mary 20c. Location	Land 2 on - City or To	1207 own, State
ages ent of it: If it y or o		1  Burial 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specif	Hemoval from State			i	/00			Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, It In Jich Exagnee.	ł	21. Signature of Funeral Service Mer		Loudoi	Park Ceme		oudon Pa			
permi Depa Impo any it		Lugar	Coth		3620 Wilke					
		23a. Part 1. Env. r the disease, o om shock, o heart failure. Li yonly	plications that caused the cone cause on each line.	death. Do no						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			NGESTIVE		12			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a con			10.00				
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rted .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	,	•	0151200	_			
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ntifica ng ph as th	ledi	IS SEMAN S								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🍽 No 9 □ Unknown	23c. If yes, outcome of pro  1  Live birth 2  4  Pregnant at time 9  Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d.	. Date of deliv Month	very Day Year
that the ed by detac		Part II. Other significant conditions of	contributing to death but not	resulting in	the underlying cause giv	ven in Part I.	23e. Did	tobacco use o	contribute to 1	the cause of death?
quires en sign uld be	od by						1 🗆	Yes 2 □ N	lo 3□ Pro	obably 4🔀 Unknown
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The I	E					_	auto perfe 1 □Yes	ormed? 2 X No	death?	2 🗆 No
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hysic this c		1 ☐ Yes 2 📜 No			patient 3 DOA	her: 4 Nursing Ho				DAZ LOZDICE
ling F	<u>ö</u>	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	ar) 28b. Ti	jury Wo		28d. Describe	how injury oc	curred	
death ctor: / the	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b	e 290 Place of Injury	At home fare	M 1 Cm, street, factory, office	]Yes 2□No	28f Location	(Street and N	lumber or Rui	ral Route Number,
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Hospita 24 hours Funeral etely filler	edical C		nysician: To the best of my miner: On the basis of exam and manner stated.							
To the within To the complex c	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date si	igned (Month,	, Day, Year)
		I New New B	urten			1445931		Ava	Ust 31	0 2009
5	-	30 Name and address of person who	completed cause of death	(Item 23a) (1	Type Print)		ANISTA			
State	e	31. Date filed (Month, Day, Year)	BWtm 540 32. Registrar's S	igrature	all !	- KITIVDI	72-51 UV	V / /	L #=	
Registra	r	2FL a T 5008	Lever 1	. 17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Hndrew Kreis 2009 2:08 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner General tounid Howard I Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Director April 25 214-58-6552 1953 District of Columbia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shouny or other traumatic event, I'm Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 United States 10005 Fox Den Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore. Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospitality Restaurant Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Andrew Paul Kreis Eleanor Morse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fern Eckhard-Kreis/ Wife 10005 Fox Den Road, Ellicott City, Maryland 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Augustate 29. permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myocardial /Medical Due t (or as a consequence of): Examiner PIVATOLU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (of as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (ocas a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? perform Eripheral Vascular Distage 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was ca e referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d

To the Funeral Direct
completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the h 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cellar Lake MM EDN 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 40 MM 29,2009 0 August В. Bryan Ketterman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | January 18, 1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 **X**M 2 ☐ F 86 216-16-6641 Maryland **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2X No Director Westminster Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21157 703 Wildlife Court death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Mental English Black, White, etc. 1 ∐Yes 2√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ⋛ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Railroad Train Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie M. Veasel Bryan B. Ketterman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 703 Wildlife Court, Westminster, Maryland 21157 Debra J. Zaruba/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition September 1. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 2009 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. Mouleld 299 Frederick road, Baltimore, Maryland 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate Cause (Final 48 400 rs **Physician** heart tailure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i the

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine D. Pollock k / MD ; UMH
32. Registrar's Signature

2018. University PKny, Baltimore MD 21218

AT 2438946 August 29,2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

follock ND

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 3 per doc 8895 9-3-09 yt State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 200<sup>y</sup>e ar 4:45 A-P **Physician** ЗŎ, Kreipl Paul J. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Rosedale Manor Care- Rossville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 10/15/ 1 913 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 95 Maryland 1 X M 2 □ F 217-09-0651 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Perry Hall Baltimore Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21128 U.S.A. 4904 Marchwood Court Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ▼ Never Married 2 Married 1 ☐Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bosel Meat Company Elementary/Secondary (0-12) College (1-4or 5+) Smoker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othin any linjuy or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Mary Johannes Louis Kreipl ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4904 Marchwood Court, Perry Hall, MD 21128 Helen O'Farrell/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/03/09 Parkville, MD Parkwood Cemetery 4 Donation 5 Dother (Specify) 21. Signafure of Funeral Service Licensee Evans Funeral Chapel & Cremet in Services 8800 Harford Rd. Parkville, MD21234 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi ck, or he at failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final disease or condition liting in death) DISEASE 142050FEDTIC RUNASCULAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burlal-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? cate has I page 2 s certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 1 Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

Funeral Director: A pletely filled in by the file 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

the Hospital or Attending Physician: The law requires that the death certificate be executed

death.

Division of Vital Records,

P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

SEP 0 1 2009 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9106

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2820 3:20F M Liszewski, D.D.S. Α. James /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F 78 April 18,1931 Maryland 213-30-7037 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examples in the mailed. 1 ☐ Yes 2 X No Director Lutherville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 1517 Sherbrook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2K Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Dentistry Dentist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Josephine Lewandowski James Liszewski ပ Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 Sherbrook Road Lutherville, MD 21093 Dolores M. Liszewski/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) . Date 31. 20a. Method of Disposition Aug. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Stanislaus Cem. 4 ☐ Donation ☐ Other (Specify) 2009 Baltimore, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 21. Simulare of Ineral S 23a. Part Linter the dil sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) CARDIAC ARREST **Physician** /Medical Due to (or as a consequence of) 30-40 MINUTES Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit P.O. Box 68760, ₹ Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Yes 2 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RICHARD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCHRAEDER

JR.

M. D. 32. Registrar's Signature 29c. License number D66@49

7601 OSLER DRIVE TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 1 per dr., g895,09/01/09dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Elma Leahy 2. Date of Death 3. Time of Death Month Year Physician 4:22 AM August 24 2009 /Medical 4a. Facility Name (If not institution) give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death to ward olumbia everal 8. Date of Birth Month, Day, Year) Nov 11, 1914 f Under 24 Hrs. Social Security Number 6 Sex (In yrs. last birthe 9. Birthplace (State or Foreign Funeral Pennsylvania Months Days Hours Min. 1 □ M 2 😾 F 94 Director 170-05-0217 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if than "natural", or Items 23a or 28a-f sho 1 ☐ Yes 2 No Director MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7317 Willow Glen Way 21075 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status TYCY'es 2 No If Yes, Give Year or Dates: '43-'45 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 ♣No Specify: 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail nt of Health and Mental Hygi If item 27 Is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mary Faber Walker Ruth ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau Henry Leahy (Son) 7317 Willow Glen Way Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Buria! 2 □ Cremation 3 □ Removal from State MD VA Cem Crownsville 8/28/09 Crownsville, MD 4 Donation 5 Dother (Specify)  $^{22}$  Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 21. Signal re of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line.

Immediate C rise (Final disease or condition resulting in death) 7250 Washington Blvd Elkridge, MD 21075 **Physician** /Medical Examiner ena Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Existo (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit neumonia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Atter this certificate has been situated funeral director, page 2 should it Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00063653 August 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shawn Evens 5755 Cedar Lone, Columbia, Maryland 21044

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month :04 A M Physician 7009 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N / A

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 1947 Maryland 12, Feb. 62 **Director** 214-50-3859 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show 1 ☐ Yes 2 XNo Directo traumatic event, the Medical Examiner must be notified Maryland | Anne Arundel Pasadena. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code U.S.A. 21122 items 23a 7927 Della Rosa Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 X Married o 1 ☐ Yes 2 🗓 No 3altimore, Maryland 21215-0036 Specify Specify. þ 3 Widowed 4 Divorced White "natural", Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) nit. Pages 1 and 2 should be filed within rartment of Health and Mental Hygiene. ortant: If item 27 is marked other than injury or other traumatic event, the Me Elementary/Secondary (0-12) EBY Brown Food Dist. 12 Warehouse Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stracener Μ. LeBon, Sr. Vallee ည Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7927 Della Rosa Court Pasadena, Maryland 21122 Deborah D. LeBon-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Crownsville V.A. Cem. 09/01/09 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 21. Signature of Fuperal Service Licensee pollins 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day signed by the atter d be detached for in the past 12 months? 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 🗌 Yes Yes 2 or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: Aft Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely f Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 965-000

Registrar
DHMH 17 Rev 1/2001

State

Greati

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month esniewski 2009 PATRICK 29 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Numbe Sex 1X M 2 D F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months 219-82-4395 August 3,1967 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Anne Arundel Pasadena Maryland 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21122 3465 Marble Arch Drive 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) A.A. County Police 12 N/A Detective 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Lesniewski Margaret Edmund 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Lesniewski (Brother) 230th Street Pasadena, Maryland 21122 2312 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/03/09 Brooklyn Park, MD. Holy Cross Cemetery 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road Pasadena, Maryland 21122 orken 47 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Duè k (or as a consequence of) resulting in death)

**Physician** /Medical Examiner

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attending physician

Box 68760

P.O.

Division of Vital Records,

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**Examiner** 

**Funeral** 

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within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of) Due to (or as a consequence of)

Examine Physician/Medical Completed by Be

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown

23c. If ves. outcome of pregnancy Live birth Pregnant at time of death

2 Fetal death 3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

600 North Wolfe St, Baltimore, MD, 21287

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

2 No 3 Probably 1 ☐ Yes 24a. Was an autopsy performed? 2 No Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tes

25. Was case referred to medical examiner? 1 Yes 2 No မ 27. Manner of Death 1 ✓ Natural Certification: 5 Pending investigation

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

4 Homicide 29a. Certifier (check only one)

2 Accident

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

29c. License number

29b. Signature and title of

Could not be

determined

29d. Date signed (Month, Day, Year)

dress of person who completed cause of death (Item 23a) (Type, Print)

Harsh Parte 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 32 **Physician** ORENZO TEADOWS Jugust 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CENTER-LOCH RAVEN (EDICAL BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 21620-6431 DECEMBER 28,1929 ALABAMA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modeal Examiner must be notified at 1 Yes 2 No BALTIMORE Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number EDMONDSON U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Mayes 2 No 1/2-48 If Yes, Give Year or Dates: 4-2/-32 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL SECURITY ADMIN SUPERVISOR MALLROOM STH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental MEADOWS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MEADOWS 2946 EDMONDSON AVE, BALTIMORE, MD ISABELLA (WIFE) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 103/2009 DWINGS MILLS, MARYLAND BARRISON FOREST CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
505EPH H: BROWN JR. FUNERAL HUME
2140 N. FULTON AVE., BALTIMORE, MD 2121 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 7ultiple Tueloma **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 Unknown 1 Yes 2 🗌 No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 1 2009

32. Registrar's Signature

EIGEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBRA

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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To the

30. Name an endress of person who completed cause of death (Item 23a) (Type, Print)

M. D.

7601 OSLER DRIVE 32, Registrar's Signature

29c. License number

DØØ6Ø495

TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** -: 15 AM <u>Shirley Johanna Miller</u> MAUST 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)

Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. 1 □ M 2 🖾 Hours 219-28-7734 August 26, 1933 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Modeal Event over must be not that at 1 ☐ Yes 2X No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21122 1166 Booth Bay Harbour Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Library Housekeeping Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental F May S. Clark Ferro 2 Sam Joseph 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 it any injury or other tra 1166 Booth Bay Harbour, Pasadena, Maryland 21122 Michael J. Miller/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1, Pages 1 ☐ Burial 2 🔯 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Amanda Heaston <u> 299 Frederick Road, Baltimore, Maryland 21228</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transi Exami and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Z Yes 2 □ No

4 □ Unknown Day Month Year 5 Other (specify) the þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Hospital or Attending Physician: The this certificate 1 Yes 2 □ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA ၉ Inpatient funeral 27. Manner of sath 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 2 Accident (Month, Day, Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death account at the cause (s). 29a. Certifie Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director:
completely filled in by the

State

29b. Signature and title of certifier

31. Date filed (Month: Day: Year)

30. Name and address &

DHMH 17 Rev 1/2001

Registrar

person who completed cause of death (Item 23a) (Type, Print)

32. P

29c. License number

Burne. MA

29d. Date signed (Month, Day, Year)

2009

			For State Registrar	State of	f Marylar	-	artment of I tificate of I	Health and Death		giene Reg. No. 20	09	27925
	Physicia	n/	1. Decedent's Name (First, Middle,			Tra			2. Date of Dea	ath	Year	3. Time of Death
	Medic Examin	al	4a. Facility Name (if not institution,	iam Matth		J L •	4b City Town o	r Location of Deatl	August	27 20 4c. County of	009	7:30 A. M
أسب	Examin	er	14811 Old York	-	,		Phoe				altim	ore
	Funeral Director		5. Social Security Number 215–22–7852	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs.	last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		y, Year)		lace (State or Foreign try) Maryland
	nd how at	٦٢	Usual Residence of Decedent  10a. State 10b. County		10c. Cir	ty, Town or Loc					1	0d. Inside City Limits
	Maryla 28a-f s stified	rect	Maryland Ba	ltimore		Ph	oenix					1 🗌 Yes 2 🔀 No
	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. At some 23a or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at the Medical Examiner must be noti	Funeral Director	10e. Street and Number 14811 Old Yor	k Road			10f. Zip Code 2113	31		10g. Citizen of W Urited of Ai	l Sta	ates
	r death or items niner mu	by Fun	11. Marital Status 1 □ Never Married 2 ☑ Marr	12. Was Deced Armed For 1 🔀 Yes	ces?	S. 13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	, White, e	etc.
903	ours afte tural", c al Exam	ted b	3 Widowed 4 Divorced	If Yes, Give Year or Da	€		☐ Yes 2 🔯 No			Specify:		white
215-	iin 72 ho ie. han "na e Medic	Completed		t's Education st grade completed) College (1-	4 or 5+)	(Give I life. Do	O NOT use retired,	during most of wor		16b. Kind of Bu	C&I	
2 2	ed with Hygien other t	Be C	12 17. Father's Name (First, Middle, L	ast)		Teleph	none Com	nun. Engi		Telepi Maiden Surname)		Company
/lan	should be file n and Mental H 7 <b>is marked o</b> raumatic eve	힏		liam Matth	neisz,	Sr.			ıa Garme	· · · · · · · · · · · · · · · · · · ·		
Baltimore, Maryland 21215-0036	12 shoul lith and I 27 is ma r trauma		19a. Informant's Name/Relationsh Mrs. Anna L. Ma		vife		ng Address (Street LO1d YO1	and Number or Ru k Road		r, City or Town, St , Marylai		
ore,	of Heal of Heal if item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3  Removal from		Place of Dispo	sition (Name of natory or other pla	·	Date ust 29,	20c. Location -		
Ĕ	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr		4 ☐ Donation 5 ☐ Other (S 21. Signatur Frieral Service L	pecify)	Ev		neral Cha	aber 50	09			, Maryland
Ba	permit. Departr Importa any inju		Tofato. 1	W/A			2325 Yo	ork Road	Timoniu	ım, Mary.	natio land	on Ctr.,P.A. 21093
	nysician/	8 8	23a. Part 1 Enter the disease, or shock, or heart failure. List o Immediate Cause (Final				er the mode of dyi	ng, such as cardiad	c or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	a. Due to (	or as a conseq							<del>√</del>
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (	or as a conseq	juence of):						
	execute ian and irial-tran	al Exal	that initiated events resulting in death) Last	c. Due to (	or as a consec	quence of):						
760	cate be physic the bu	edical		d								
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 🗌 Fet nant at time of	tal death 3	Ectopic pregnan Other (specify)	cy		23d. Date Mor	e of delive	ery Day Year
P.O.	v requires that the de been signed by the should be detached	by Ph	Part II. Other significant condition	ns contributing to de	eath but not re	sulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contri	bute to th	ne cause of death?
rds,	een sig ould b	sted										pably 4 X Unknown
Reco	sician: The law n certificate has b lirector, page 2 sh	Completed							24a. Was autop perfo	osy p ormed? d	vere autor rior to cor eath? Yes	psy findings available mpletion of cause of
25. Was case referred to medical examiner?  1  Yes 2 No 1  Inpatient 2 ER/Outpatient 3 DOA Other:  4  Nursing Home 5 X Residence 6 Other (Specify)												
n of V	Attending Physician: er death. ector: After this certific by the funeral director,	ate: To	27. Manner of Death  1 Natural 5 Pendir	g 28a. Date		28b. Time of injury	28c. Inju wor	ry at		now injury occurre		)
Divisio	• Hospital or Attendii 24 hours after death. • Funeral Director: A eted filled in by the fu	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	Street and Numbe vn, State)	r or Rural	Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2 Medical E	Physician: To the b xaminer: On the bas Nurse Practioner:	is of examination	on and/or inves	tigation, in my opin	ion, death occurred	at the time, date a	and place, and due	to the car	use(s) and manner stated.
	To the comp	2	29b. Signature and title of certifier	2 ,		.,	29c. Licens	se number		29d, Date signed	(Month, I	Day, Year)
			Homi !	bux CRN				19194		Myust	27.	2009
+1			30. Name and address of person  Main Gra	1 6701	N.Ch	arless	st Tows	01, Mi	2120	7		
ľ	Sta Registr		31. Date filed (Month, Day, Year) SEP () 1 2	09 532. R	egistrar's Sign	ature hav	as of					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Vernon Paul 07:15AM McDonald AUGUST 28, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 X M 2 □ F 217-18-5153 86 **Director** 30. 1923 | Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc. Pedical Examiner must by redified at 1 ☐ Yes 2 No Maryland Directo Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13801 York Road 21030 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: WWII þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hecht Company College (1-4or 5+) Elementary/Secondary (0-12) Regional Head of Department Stores Design and Display

18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and 2 should be fill.

Health and Mental H

tem 27 is marked oth Be John Thomas McDonald Catherine Lottie Bell Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Myra Krieger Personal Rep. Cockeysville, Maryland PO BOX 57 21030 altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Atlantic Crematory 8/31/2009 Glen Burnie, Maryland 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of the eral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland Inc. Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician LARGE CEREBELLAR BLEED /Medical resulting in death) Due to (or as a consequence of): Examiner RENAL MASS WITH BRAIN METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed ling physician and e as the burial-trans ACUTE RENAL FAILURE P.O. Box 68760, € Due to (or as a consequence of) Physician/Medical sate has been signed by the attending page 2 should be detached for use as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 

Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 NO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier within 24 ho

To the Fune

completely f (Check only the 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier 2009 28 0 S.M D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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32. Re

istrar's Signature

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OSLER DRIVE

TOWSON, MARYLAND 21204

09-06665 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Ray Main State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 26, 2009 James Ray Main 0636 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 1120 Gorsuch Avenue 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Foreign Country) Months Days Hours **Director** Nov. 21, 1931 220-32-4456 77 W. VA 1Х м 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 28a-f show is 23a or 28a-f show e notified at once. N/A Baltimore MD 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1120 Gorsuch Avenue 21218 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 1X Yes Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify: White 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Meat Cutter <u>Eskay Meat Company</u> ment of Health and Mental Hygiene 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Helen Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 is Barbara Main - Wife 1120 Gorsuch Avenue, Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 X Cremation 3 Removal from State Burial 8-28-2009 Atlantic Crematroy Glen Burnie, MD Other Specify Donation 5 Other Specify:
 21. Signature of Furneral Service Licencee 22. Name and Address of Facility Ambrose Funeral Home, Inc. Sulphur Spring Rd., Arbutus, MD Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and fe. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - trans Sa **AMENDED** UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 After this certificate has been signed by the attention of director, page 2 should be detached for a 1 Yes 2 No 9 Unknown Unknown 돈 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 1 Yes 2 No 5 Pending the Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) To the Hospital o within 24 hours af To the Funeral D (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. August 26, 2009 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year SEP 0 1 20 State Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Keith Darryl Miles, Sr. MGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death County of Death Examiner BURNIE AMME SALTIMORE WASHINGTON MEDICAP CENTER GLEN 8. Date of Birth (Month, Day, ) July 25, Social Security Number 6. Sex\_ 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Year) Months Davs Hours Min 264-21-3694 49 Director 1960 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 No Directo Maryland Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 United States 723 Delaware Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □Yes 2 🛱 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ≥ Specify White 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Truck Driver Giant Food Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Leonard Miles, Sr. Joyce Leona House permit. Pages 1 and 2 sho Department of Health and Important: If Item 27 is m. any injury or other traum. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Theresa R. Miles / Wife 723 Delaware Avenue Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **\***Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 09/02/2009 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services, PA; 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10H-40D disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be execuand burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical SE IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Chack only one) and manner stated. To the within 2 and stle of ertifier 29b. Signatud 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

pare and address of person who con

31. Date filed (Month, Day,

gause of death (Item 23a) (Type, Print)

			For State	State of Maryla	•	ertment of F Frificate of			- 0000	07000
			Registrar  1. Decedent's Name (First, Middle, La	st)	Cei	inicate of	Dealli	2. Date of Deat	eg. No. 2	3. Time of Death
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-	/Medio		4a. Facility Name (If not institution, give		110 00 1101		r Location of Death		4c. County of Death	
			Stella Maris Ho	·		Timor			Baltimor	
	Funeral		5. Social Security Number 6. S 216-38-1623	WM 2□F	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birth Con	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	96				April	18,1913	Ireland
	ryland show	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits
	8a-fs	octo	Maryland Baltim	ore	Timon					1 □Yes 2 No
	with the	ä	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	untry?
	heath ns 23	era	2525 Pot Spring  11. Marital Status	12. Was Decedent Ever in	U.S. 13. \	21093 Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	U.S.A.	ican Indian,
. ي	after o	by Funeral Directo	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give		f Yes, specity Cub I □Yes 2[X]No		Rican, etc.)	Black, White	
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The same of	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ITALA ODCE.		19a. Informant's Name/Relationship (Rev. William P. F	. Fellow					; City or Town, State, Z	
	Heal tem 2		20a. Method of Disposition	<u> </u>		Sition (Name of natory or other place	ick Avenu		more, MD 21	
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AUGUST 29, Baltimore,	partm porta y Inju		21. Signature of Fytheral Service Oce	7 // /7 -9-		. Name and Addre		· · · · · · · · · · · · · · · · · · ·	,_Maryland	
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	/Medical Examiner		Toolang in doutin	Due to (or as a cons	equence of):					
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118	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionsyling Cause (Disease or injury that initiated events	c						
00,	cate be executed physician and the burial-transit	Ĕ	resulting in death) Last	Due to (or as a cons	equence of):					
9289	icate physics the b	dical		d						
Box 6	eath certific attending p for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy				23d. Date of deli	verv
B	death e atte d for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnand Other <i>(specify)</i> _	cy		Month	Day Year
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Sio	tendir eath. or: Ai	catic	2 Accident investigatio	n	.,.,,		]Yes 2□No			
Division	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		home, farm, strecify)	eet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	spital ours a neral I		29a. Certifier 1 ☐ Certifying P	h <b>ysician</b> : To the best of my k	nowledge, deat	occurred at the f	ime, date and place	and due to the c	ause(s) and manner as	stated
	te Hos 7 24 h 1e Fur bletely	Medical	(Check only 2 Medical Exa	miner: On the basis of exam ition@aner stated.						
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	1DX,			completed cause of death (I						
	Sta	te	JACKIE JONES 31. Date filed (Month, Day, Year)	2300 DU 32. Registrar's Sig		LLEY RD.	TIMONIU	JM, MD 21	1093	
	Registr		SEP 0.1	2009 Ceneus	p. 1	garre				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 28, 2009 10:35 A.M Robert Benjamin Miller /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Dove House Westminster 9. Birthplace (State or Foreign Country) West If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours **X**X M 2□ F Director 80 April 24,1929 232-32-8679 <del>Virginia</del> the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes ZYNo Director MD Westminster Carrol1 10e. Street and Number 10g. Citizen of What Country? should be filed within 72 hours after death with and Mental Hygiene. 1403 Ogg Drive 21157 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes XXNo If Yes, Give Year or Dates: 1 ☐ Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Geo. Techinical Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Miller Haze7 Jarvis ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once. 1403 Ogg Drive, Westminster, MD 21157 Mary L. Miller / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Lutheran 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify)

Signature of Furieral Service Licensee Sep. 2, 2009 Manchester, MD Cemetery

22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I medicte Cause (Final di east or condition result g in death) **Physician** NON-small cell Lung CANCER 14/09-8/28/0 /Medical ue to (or as a consequence of) Examiner Se uentially list conditions, if my, leading to immediate Ent a line lyin Cause Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Injury 1 Natural 5 Pending s after death. M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff
To the Funeral D
completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

barkel

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert

SEP 0 1 2009

31. Date filed (Month, Day,

D006459=

Center St Westminster MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3 Time of Death August August 28 pay 10:00 P M 2009 Clora Joy Nixdorf 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Manor Care- Ruxton Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1 □ M 90 212-12-5257 May 13, 1919 Mary land Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Towson MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7001 North Charles Street 21204 U.S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) May Heise Herbert Joy 19a. Informant's Name/Relationship (Type, Print) Great 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wellein/Nephew 8123 Glen ArborDrive, Baltimore, MD 21237 Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition More land Metor 1 a 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/01/09 Parkville, MD Park 21. Sign Tre of Funeral Service Licensee Evans Funeral Capel & Cremation Services 8800 HarfordRd. Parkville, MD 21 234 23a. Part 1. Enter the disease, or complications that caused the death, spock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, liate Cause (Final in m Plate Cause s se or condition r sulting in death) metastatic Due to (or as a consequence of): mention if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1□ Yes 2□ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical the as nse Completed

be executed To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After it

Be

၉

Certification:

Medical

State

Registrar

Division or Vital Records. P.O. Box 68760.

Physician;

Mexicalor

23b. Was decedent pregnant

27. Manyer of Death 1 Naturai

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

1 ☐ Yes 22 No

> 5 ☐ Pending investigation 6 ☐ Could not be

determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

J. HIROARA MO

and manner stated. 29b. Signature and title of certifier

29c. License number P5R749 29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson 7505 OS (EX Drive

31. Date filed (Month, Day, Year)

SEP 0 1 2009

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) O Wonth 30 2009 Rose Helen Norman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosadale Baltimor Franklin Square HOZOH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day August 18 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Min. 213 05 2660 1 □ M 2 🙀 F Months Days Hours 100 Baltimore, Maryland Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location Baltimore County 1 ☐ Yes 2X No Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 1000 Franklin Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XXVo Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Epstein's Dept. Store Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosario Serio Giovanni Faraino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Overbrook Drive Bel Air, Maryland 21014-0182 19a. Informant's Name/Relationship (Type. Print) Concetta Faraino 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Baltimore, Maryland 9/2/09 Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Linensee 22. Name and Address of Facility Lassahn Funeral Home, Inc Baltimore, Maryland 21236 7401Belair Road Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

attending physician

sate has been signed by the page 2 should be detached

After this certificate

after death.

To the Hospital or within 24 hours af To the Funeral D

funeral director,

the

completely filled in by

þ

Completed

Be

Certification: To

ca

the for use as

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

and 2 should be filed within 72 hours after death with the Maryland

land 21215-0036

Itimore, Mary

27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expressment rass to rutified at

Health and Mental Hygiene.

permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr once.

**Funeral Director** 

Completed by

Be

ပ

Examiner burial-trar

23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death Do not enter the mode of dving, such as cardiac or respiratory arrest. Cardiopulmonat Due to (or as consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant

Immediate Cause (Final

disease or condition resulting in death)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery 23e. Did tobacco use contribute to the cause of death?

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

Yes 2 No

1 🗌 Yes

24b. Were autopsy findings available prior to completion of cause of death?

MINUTE

1 □Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 □ No

2 No 3 Probably 4 Unknown

examiner?	relement	o medica
1 ☐ Yes		
a7 11		

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

1 Inpatient

Hospital:

2 ☑ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Drive Baltimore, MD 21237

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

29a. Certifier (Check only one)

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) AUGUST 30, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,9000 Franklin 19 Square

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Day 2 009 Physician 12:45 Agnes O'Neill, OSF Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) Nov. 3, 1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Min. 1□ M 2□F Days Hours Months Ireland 214-64-9132 96 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Examinar must be notified at XX Yes 2 □ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 3725 Ellerslie Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐Yes 2√√No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Moriarty Patrick O'Neill ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and then an ament of Health an and 27 Is Community Jodene Wydeven-Religious 3725 Ellerslie Avenue- Baltimore, Maryland member Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Motherhouse Cemetery Sept. 4, 2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final RESPIRATORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ner The law requires that the death certificate be executed Exami and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Onknown peen Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No 1 ☐Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည this eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar SABAEVA.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELENA

5601

32. Registrar's Signature

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LOCK RAVEN BLUD BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 447 М RNESTINE 09 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hopkins Bay, in Mal, and Center Baltimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-4-1919 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Days 90 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Expring must be recitied at ury or other traumatic event, I'm Medical Expring must be recitied at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1XYes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2511 SEAMON AVENUE 21225 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 X No δ Specify: 3 XWidowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSEWORK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ISABELLE CURRY** ဂ္ CARLTON RAINES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. CAROLYN BOLDEN/DAUGHTER 2511 SEAMON AVE. BALTIMORE, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DRurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 9-3-2009 GLEN BURNIE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signatore of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Presmonit 2 weeks nemical disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Weeks Pheumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) P.O. I 1 □Yes 2 □ No. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐Yes 2 ☐ No 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation nours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOVIL Bultinox, MD ZIZZ Easken AN ASHUL D. 4040 32. Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jenniffer Poe 8:55 A M 2009 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Davs Hours Min. 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX May 27, 1959 Country) 213-76-5683 50 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD N/A Baltimore Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1204 Union Avenue 21211 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 XX Baltimore, Maryland 21215-0036 1 Tes 2XXNo Specify: If Yes, Give Specify: White "natural", 3 Widowed 4XXDivorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Homemaker

Not use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Ligameri Joanne Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley White (Daughter) 3164 Remington Avenue Balto. MD21211 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/29/09 Glen Burnie, MD e of Functal Service License 22. Name and Address of Facility Burgee-Henss-Seitz 3631 Falls Road Ba Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in the cause (Disease or linjury) Examine attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ☐ Live Birth 2 ☐ Fetal uea.
☐ Pregnant at time of death
☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year been signed by the should be detached Hospital or Attending Physician; The law requires that the 24 hours after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗌 No 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 MOther (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending

Certificate: To work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basic of examination and/or inventional. Medical 29a. Certifier

(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) and title of certif 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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egistrar's Signatur

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death **Physician** 18: 34 (PM) Ralph Poist 08 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Franklin Square Koschale Battimore HOSOIta | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Apr. 20, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 212-48-1686 62 1947 **Director** Pennsylvania Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ortant: If item 27 is merked other than "natural", or items 23a or 28a-f sho Injury or other traumetic event, the Medical Event and the notified at 1 ☐ Yes 2 No Directo Baltimore Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 63 Akin Circle 21220 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∏Yes 2 ŽiNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. ģ Specify: 3 ☐ Widowed 4 ₺ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be d 2 should be fill the and Mental he 7 is merked oth Mildred Arlene Hufnagle ည Ralph Bernard Poist Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sl: Department of Health and Important: If item 27 Is n eny Injury or other traum Elaine M. Amoss / Sister P.O. Box 13, Mendenhall, PA 19357 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 ☐ Cremation 3 🗀 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 9-2-09 Bel Air, Maryland 21. Signature of Funeral Service Licens 22 Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complication the shock, or heart failure. List only one is us-on was the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Of MOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed hypertensi Division of Vital Records, P.O. Box 68760 attending physician and for use as the burial-trar Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Phoumonia-Bilateral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **V** No 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 1 V Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 124 hours after death.

le Funeral Director: A
bletely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 ho

To the Fune

completely f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **RESOUCE** 08/29109 -0

State Registrar

31. Date filed (Month, Day, Year)

SEP 0 1 2009

DHMH 17 Rev 1/2001

Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HO 9000 Franklin Square
nth, Day, Year)
32. Registrar's Signature

			For State Registrar  1. Decedent's Name (First, Middle, La	st)	•	tificate of I		2. Date of Dea	Reg. No.		3. Time of Death
	Physicia		JESSE R	PRESLEY				Month 3	3 O	Year 09	7:09AM
	Medic/ Examin	_	4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or			4c. Count	ty of Death	•
-			JOHNS HOPKINS				TIMOL			I O Diath	lana (Ctata au Fansiau
	uneral irector		219-32-2790	Sex 1 M 2 □ F 7. Age (In ) 73	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v, Year)	Cour	lace (State or Foreign try) H
land	MC #I	1	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
Mary	if sh	ţō	MD Baltin	nore	Baltin	nore					1 ∐Yes 2 ∐ANo
th the	or 28s	)irec	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
ath wi	23a ust b	ral	7264 Gough St			21224			USZ		
er des	items	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13. \	Was Decedent of H f Yes, specify Cuba	fispanic Origin? ( an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Ra	ace - Americ ack, White, (	
nours aft	l", or	þ	1 ☐ Never Married 2 Ă Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  **Tyes 2 \sum No If Yes, Give KO Year or Dates:	rea	1∐Yes 2 <mark>X</mark> No	Specify:		Spec	ify: Wh	ite
U Z IZ I 3-0030 filed within 72 hours after death with the Maryland Hydiona	natura ical E	Completed	15. Decedent's E (Specify only highest gr	ducation	16a, Dece	dent's Usual Occup		arkina	16b. Kind of	Business/Inc	dustry
ighi d	Jan "I	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d) -	g	Co	n a + mi	ction
iled w	ther th	S	17. Father's Name (First, Middle, Las	*)	P1.	le Drive		me (First, Middle,			ICC10II
e e	c eve	To Be	Jesse Presley	,				ude Dee			
sho	tenem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exercited must be notified at	ř	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street					Code)
2 2 4	27 is er tra		Margaret A. Pi	cesley-Wife	7264	4 Gough	St., B	altimor			
	If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	b. Place of Dispo cemetery, crer	sition (Name of matory or other place	ce)	Date	20c. Location	•	
Dallillor	tant: jury		4 ☐ Donation 5 ☐ Other (Spec	fy)		v Cremat			Balti		
permit.	Important: If item 2 any injury or other once.		21. Signature of Funeral Service/Lice	Asee		2. Name and Addre	D	radley- Spring	Ashto: Road	n Fun , 212	eral Hom 222
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the o							Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	4.4	TATIC	COLON	CANCO	FR			Onset and Death
	edical ıminer		resulting in death)	Due to (or as a con	sequence of):			-			
LAC		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a con	sequence of):						
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_							
o, exec	an an rial-tra		resulting in death) Last	Due to (or as a con	sequence of):						
oo/ou, rtificate be executed	ig physician and as the burial-transit	<i>l</i> edical		d							
× o	ding p	/Mec	IF FEMALE:	23c. If yes, outcome of pro	adnancy				204 5	Data of dally	0.00
eath ce	atten for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	СУ			Date of deliv Month	Day Year
the d	After this certificate has been signed by the attendir funeral director, page 2 should be detached for use	Physician/ľ	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
5, F	jned b e deta	by PI	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ontribute to t	he cause of death?
cords, w requires t	en sig							. 10	Yes 2 □ No	3 Pro	pably 4 ☐ Unknown
law r	nas be	Completed						24a. Was autor	osy	prior to co	ppsy findings available impletion of cause of
r The	cate ;	Con						perfo 1 ☐ Yes	rmed? 2 <b>X</b> No	death? 1 □ Yes	2 □No
VILCAI Sician:	certif	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		Oth	or:	eath (Check only o			
2 4 C	er this eral di	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury (Month, Day, Yea	2 ER/Outpatie	III 3 LI DOA	4 LI Nursing	Home 5 ☐ Resi 28d. Describe			<i>fy)</i>
Attending Phy	r: Afte	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury		rk? ]Yes 2∐No				
r Atte	recto	Certification:	3 ☐ Suicide 6 ☐ Could not determine		At home, farm, str pecify)	reet, factory, office		28f. Location ( City or To		mber or Run	al Route Number,
ital o	led ir										
UNISION OF VITAL DECOMAS, F. O. BOX To the Hospital or Attending Physician: The law requires that the death cer	To the Funeral Director:	Medical	29a. Certifier  (Check only one)  1 Certifying F 2 Medical Example 1	Physician: To the best of my aminer: On the basis of exa and manner stated.	r knowledge, deal mination and/or ir	th occurred at the to estigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	date and plac	manner as e, and due t	o the cause(s)
To th	To th	Me	29b. Signature and title of pertifier			29c. Licens			29d. Date sig		
	1					RE	ts - 00C		AVGUS	T 30,	2009
5	1 1		30. Name and address of person who		(Item 23a) (Type,	Print) EATERN	( AVENI)	E BAIT	TIM OR E	, Mr	2 laz U
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature			- WILL			7
	Registr	ar	SEP 0 1 2009	General S.	park	1					
DHMH 1	17 Rev 1/2	001		/ 100	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend #9 per FH g896 10/1/09 TT TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** August 2009 S. Parsons Pau1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wighington Medical Center BAltimore Glen BURNIE Anne If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Funeral Year) Months 1 X M 2 □ F Days Hours 82 August 12,1927 **Director** 220-22-6019 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10b. County th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be molified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena SNOS H 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number and 2 should be filed within 72 hours after death with U.S.A. Funeral 810 207th Street 21122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. If Yes, Give Year or Dates Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Factory Worker Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Ray ည Jessie Parsons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. John Shifflett (Friend) 207th Street Pasadena, Maryland 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 108/26/09 Bayview Crematory Baltimore. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal -Ailure Physician /Medical Due to (or as a consequence of): Examiner tension Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dije to for as a consecuring of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 □Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending nours after death. neral Director: Af filled in by the fur investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifier August 23, 2009 0027415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Medical Center Mb BAltimor TA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILLIAM J. ROBERTS AUGUST 26 2009 3:13P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore County 326 Elinor Avenue 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 13, 1924 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days **X**M 2□ F Months Hours 219-18-9308 Director 85 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be nother at 1 ☐ Yes 2 ☐ No Director Marvland Baltimore Baltimore County 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral [ 326 Elinor Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Korean 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: þ Specify:White 3 Widowed 4 □ Divorced Completed Conflict 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Supervisor Telephone Co. yrs. Department of Health and Mental Hygis Important: If item 27 is marked other is any injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles J. Roberts Grace M. Fillmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen D. Roberts (Son) 108 Sillen Plantation Rd. Stevensville, Md. 21666 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XIX Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemeterv 8-31-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. 7. Lassahn Funeral Home Balto. Md. ssakn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Discust **Physician** lenotu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Tyes 2 No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 ☐ Yes 2 1No 1 ☐ Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending safter decral Director: Atr 1 □ Yes 2 □ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 30. Name and address of person who completed rause of death (Item 23a) (Type, Print) 6530 WAITHANDEVENUE 31. Date filed (Month SEP

Registrar DHMH 17 Rev 1/2001

State

Year

		For State Registrar		partment of Health and Mertificate of Death	lental Hygier Reg. 1	0000	27940
Dhysisis		Decedent's Name (First, Middle, Last)	0		2. Date of Death	Day Year	3. Time of Death
Physicia /Medic		Jean	Kobinson		Aug. 2	6,2009	8:06PM
Examine	er	4a. Facility Name (If not institution, give s 4306 Plain-fiel	treet and number)	4b. City, Town, or Location of Death	,	4c. County of Death	4
Funeral Director		5. Social Security Number 6. Sex 212-34-3702 1	M 2 F 7. Age (In yrs. last birthday	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Oct 31	9. Birth Cou	place (State or Foreign
pur *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or L	ocation			10d. Inside City Limits
Maryla a-f sho	ctor	Maryland N/A	- Too. Oity, Town of E	Baltimore			1 ☑Yes 2 ☐ No
after death with the Marylan or Items 23a or 28a-f show mirer must be a cellined at	al Director	10e. Steet and Number 4306 Plain Fiel	d Ave.	10f. Zip Code 21206	10g.	Citizen of What Cou	Ztry?
S T	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 □Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Black	
"na"	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired) Home Maker	16b.	Kind of Business/In	ndustry
permit. Pages 1 and 2 should be filed within popartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Monce.	To Be Co	17. Father's Name (First, Middle, Last) Waster Gardrer	,	1/	(First, Middle, Maid	en Surname)	
and 2 shou talth and N 27 is mar er traumat		19a. Informant's Name/Belationship (Tyr. Wanda Kobinson	pe. Print) 19b. Mai -daughter 430	ling Address (Street and Number or Rura  Be Platafield Ave	al Route Number, Cit Baltim	y or Town, State, Zij	o code) Hall
Pages 1 ament of He ant: If Item		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place of Disposer Commetery, cree	position (Name of ematory or other place)  Lewnal Park 9	20c. 12 69 Ra	Location - City or To	own, State Maryland
permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service License	Parker 3	22. Name and Address of Facility Flank 512 Frederick Av	er Fyrera	Home P.I.	4. 21229 Yland
		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death. Do not ele cause on each line.	nter the mode of dying, such as cardiac o	or respiratory arrest,	1	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	Dierece			6 mo
Examiner	Jer	Sequentially list conditions, if any, leading to immediate out.	Due to (or as a consequence of):				
xecuted and Il-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
cate be ohysicia the bur	dical	d					
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv	very Day Year
ss that gned b	양 타	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to t	the cause of death?
require	eted	(ongethive	heart Gilve		1 Tes	7	bably 4 Unknown
n: The law ficate has I r, page 2 s	Completed		W		24a. Was an autopsy performed' 1 □ Yes 2	?   death?	opsy findings available ompletion of cause of 2  □ No
ysiciau is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death		6 ☐ Other (Speci	ifu)
ath. r: After th	Certification: To	27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) 28b. Time Injury	of 28c. Injury at 2	28d. Describe how in		<i>y</i>
tal or Atters as after de al Directo ed in by the	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
the Hospi iin 24 hour ihe Funer	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys 2 → Medical Examin	ician: To the best of my knowledge, dea er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)
To t To T	Σ	29b. Signature and title of certifier	Leun WI	29c. License number		Date signed (Month, 3' 31' 6 9	, Day, Year)
		30. Name and address of person who col	npleted cause of death (Item 23a) (Type	Print) Dantel R.	Howard, wo		
Stat Registra	•	31. Date filed (Month, Day, Year) SEP 0 1 2009	32. Registrar's Signature	w 21201			
3,100		ATI AT CAAS			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 9:45PM SPENICE KAYMOND 22,2009 AUGUST 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9123 Thistledown Dwings Road Mills Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs, last birthday) 8. Date of Birth (Month, Day, 1 M M 2 □ F Months Days Hours Min. 62 218-44-1644 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 No OWINGS MILLS MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13.5.A THISTLEDOWN ROAD 211 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION IRTH GRADE OREMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SPENCE CATHERINE ALONZO 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9123 This Hedown Rd, Dwings Mills, MD 21117 Sheila Anne Spence (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SOODLAWN CEMETERY CB/29/2009 BALTIMORE, MARYLAND 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Whoms SUSEPH H. BROWN JR. FUNERAL HOME SULLOWN SIHD N. FULTON AVE., BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) O. Tall Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify)

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760.

<u>Р</u> О

Division of Vital Records,

injury o

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

ဥ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

or other traumatic event, the Medical Examiner must be notified at

Examiner

Physician/Medical

≥

Completed

æ

Certification: To

Medical

reral Director: A

within 24 hours a

9 Unknown

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 24a. Was an

2 No 3 Probably 4 Unknown

autopsy performed? 2 No 1 □Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural
2 Accident

3 ☐ Suicide

4 ☐ Homicide

9 Unknown

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐Yes 2 ☐No

Other: 4 ☐ Nursing Home 5 Presidence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier

DAUID

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin S. ETTINGEY MD

Johns

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

22. Registrar's Signature

DHMH 17 Rev 1/2001

			Pleas	se Type or Pri				-	_	ble.		
			For State	State of M	•	epartment of I Certificate of	Health and Me Death			19	270	16.5
			Registrar  1. Decedent's Name (First, Middle,	/ act)		oci illicate oi		Reg.  Date of Death	No.		3. Time of	Death
	Physici /Medi		DORIS	D.	SA	LIEY			Day &5,8	Year 2009	5:30	OPM
Examir			4a. Facility Name (If not institution,	give street and number,	)		or Location of Death	4c. County of De				
and the			918 WILD	COOD	PKWY	BAL	TIMOR	E	NI	A		
	Funeral Director		5. Social Security Number 219-32-2759	6. Sex 7. A(	ge (In yrs. last birthe	Months   Days	Hours Min.	Date of Birth (Month, Day, Ye	ear) 1937	9. Birthpla Countr	ce (State o. y) YLAK	-
	pu ,		Usual Residence of Decedent		10 C7 T	-1				100	l lacida Cit	to a L I amoldon
	shov	_	10a. State 10b. County	1-	10c. City, Town of	or Location				100	d. Inside Cit	
	Sa-fs	Director	MARYLAND	IA	P	ALTIMI	DRE				1 Yes	2   NO
	or 28	)ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of V	Vhat Country	/?	
	h wii 23a		918 WILDW	DOD PI	KWY	2/0	229	(	1.5.1	A.		
	ms (	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No-		e - Americar		
က္	r ite	F	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? ed 1 ☐ Yes 2 🛣	No			can, etc.)	Blac	k, White, etc	λ.	
03	urs a	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 1 No	Specify:		Specify	BLA	ACK	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene whatural", or items 23a or 28a-f show only, the Mexical Exeminer must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a. D	ecedent's Usual Occu	pation	161	o. Kind of Bu	ısiness/Indu	stry	
7.	7 nin 7	ble	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or		Give kind of work done ife. DO NOT use retire	during most of working					
21	r tha	E	12TH CRADE	Conege (1-40)	211	3RARY 1	ECHNICIA	NIII CC	PPIN	STAT	EU	WIL
	be filed within 72 hours after death with the Marylar ntal Hygiene. So or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Markeil Exporter must be notified at	Be C	17. Father's Name (First, Middle, L	ast)			18. Mother's Name (	First, Middle, Mai	den Surnam	ie)		
an	hould be nd Menta marked matic ev	To B	HIRAM	(2)	RIME	5	FLOREN	IME		3M.	ITH	
Maryland	i 2 should be fi h and Mental I 7 is marked ol traumatic eve	-	19a. Informant's Name/Relationsh				and Number or Rural		ity or Town,	State, Zip C	code)	
N	nd 2 salth ar 27 is r trau			NITH (DAU			STEREY R				,	218
စ်	# # # # # #	-	20a. Method of Disposition	77777	20h Place of D	isposition /Name of	Dat		. Location -			000
5	e = 2,9		1 ☐ Burial 2 🗹 Cremation		cemetery,	crematory or other pla	natur 09/01/	2000 10				
臣	nit. Pa artmer ortant: injury e.		4 □ Donation 5 □ Other (Sp		FUNERAL							
Baltimore,	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service L	censee	100:	Truccoul 12	12 001. NOT	TR. FUN	UZRA	C M	OME	
	402.00		whi	ch N.W		214DNIF	PLIDNA	15.10HL	111110	41111	La Cara	321/
			23a. Part 1. Enter the disease, or of shock, or heart failure. List of	complications that cause nly one cause on each l	d the death. Do no ine.	t enter the mode of dy	ng, such as cardiac or	respiratory arrest	,	1	Approximate nterval Bet Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	LUM	18 C	INCER				,	Alset and L	Jean
	/Medical		resulting in death)	Due to (or as	a consequence of)							
	Examiner			h								
		ner	Sequentially list conditions, if any, leading to immediate baces. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of)	:				.0		
	executed n and ial-transit	Examiner	Cause (Disease or injury									
oʻ	execut an and ial-tran	Exa	resulting in death) Last	Due to (or as	a consequence of)	:						
92		ğ		d								
9289	death certificate be e attending physicia d for use as the bu	ğ		0.								
×	th certi ending r use a	Š	IF FEMALE:	23c. If yes, outcome	e of pregnancy				334 Dat	te of deliver	,	
Вох	atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	су					Year
Ö	at the de by the tached	Physician/Medica	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown	at time of doutin	o E other (specify)	·					
σ.	that the		Part II. Other significant condition	s contributing to death b	out not resulting in the	ne underlyjna cause oi	ven in Part I	23e. Did tobac	co use cont	ribute to the	cause of d	jeath?
Records,	es igr	þ						1 Yes		3 ☐ Probai		
20	w requires s been sign should be	ompleted						i\€ Yes	Z LINU	J LIODA		ZINIIUWI
Ö	aw as b	ed d						24a. Was an autopsy	24b.	Were autops	y findings	available
Œ	The I ite ha	ПО						performed		death?	DNo	

Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

To the Hospital or Attending Physiclan:

Medical Certification: To Be

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

27. Manne of Death 1 Natural 2 🗌 Accident 3 🗌 Suicide 4 ☐ Homicide

25. Was case referred to medical examiner?
1 Yes 2 No

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

5 60

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear Month **Physician**  $P^{M}$ Ann Strosnider Ruth 28 2009 5:15 August /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore St. Claire Lane 7866 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F 7/27/1925 236-38-1210 84 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantists remained at 1 Tyes 2X No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. St. Claire Lane 21222 7866 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No If Yes Give Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Bottle Cap Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smoot Laura Ernest မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Vailthorn Road, Middle River, MD 21220 Judith Blanchard/ Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 8/31/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Afterockruh Condi Vosila Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 1∐Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 🔀 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

the within To the

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Box (

Records,

256 North Dist Rd, Paltonia, Mrs 1856 North Dist Rd, Paltonia, Mrs 18 Signature backed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Year Month Physician 430AM 8 27 Etta E. Sprouse 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN HOSPITAL CENTER Rosedal Baltimore Square If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Min. 1 □ M 2 🕱 F Days Hours Oct. 15, 1920 Director 293-22-3512 88 Ohio Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County ed other than "natural", or items 23a or 28a-f sl event, the Medical Examiner must be notified 1 ☐ Yes 2 X No Funeral Director Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 64 Transverse 21220 Avenue United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Factory Machine Ocerator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Bruce Sarah Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frankie M. Brown/Daughter 64 Transverse Avenue, Baltimore, Maryland 21220 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 28. 1 ☐ Burial 2 ☐ \*\*Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 2009 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 299 Frederick Road, Baltimore, Maryland 21228 shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🖃 No 1 ☐ Yes 2 ☐ No 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

9000

31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

OHN

29d. Date signed (Month, Day, Year)

21237

AUGUST, 27,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day John Norman Kendall Smith 2009 7:00A Aug 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster . Age (In yrs. last birthday)
47 yrs. If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 4 0 4 - 9 6 - 3 3 4 2 Months Days Hours July 19,1962 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County MD Carroll Westminster 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 1416 Chazadale Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School 12 Instructor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HOSKINS John Henry Smith Lois Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Chazadale Way, Westminster, MD 21157 Susan J. Smith-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-30-2009 Sykesville, MD 4 □ Donation 5 □ Other (Specify) All County Crem. 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licensee Homas D. 254 E. Main St. Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Vear Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

3a or 28a-f show

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

d other than "natural", or items 23a event, the Medical Examiner inust to

27 is marked o traumatic eve

Item 27 other t

permit. Pages Department of Important; If It any Injury or o

, Or

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ģ Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

and manner stated.

Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

5 ☐ Pending investigation 6 ☐ Could not be Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJAY Behati 200 McMorial Ave. Westninsten, MD 21157 Behari

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 ate of Waryland & Deposition of the alth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Der monds 2009 ICK 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Count Middle If Under 24 Hrs. State Hirport *jartins* If Under 1 Year 8. Date of Birth (Month, Day March 7, ocial Security Number Age (In yrs. last birthday) Birthplace (State or Forei
Country) **Funeral** , Year) 1942 Days Months Hours 1**XX**M 2□ F 6 Yrs. Director Bermuda unknown Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Wedical Examinat must be published at N/A Pembrook East Bermuda 1 ☐ Yes 2√√No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 North Shore Road HM14 British Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 | Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes XXNo Black Be Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Owner of Radio Station 12 Broadcasting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be f nent of Health and Mental ant: If item 27 is marked o Earl Simons AlmaLouise Symonds-Tuzo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Symonds (Wife) 158 North Shore Rd. Pembrook East, Bermuda HM14 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X xurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 8/29/09 Baltimore, MD 21. Signature of Funeral/Service Licentee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. Juh 3631 Falls Road Balto, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cance disease or condition resulting in death) Lung /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, physician the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 □Yes 2 □No page 2 should be detached 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, semo 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 24 h and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) osali D60203 WA LIB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rosalyn 600 Worth woirest, Balt MD 21287 Juergens

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year Physician/ Month 25. Peter David Savelle August 9:33 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min California 564-40-7668 Director 74 June Usual Residence of Decedent 28a-f show 10b. County 10a State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗌 Yes 2 🔀 No Maryland Baltimore Towson 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a915 Cromwell Bridge Road 21286 filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced er than "natur, the Medical E Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Contracting Quality Engineer is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Maxwell H. Savelle Carmen Zappino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Wendy J. Savelle/Wife 915 Cromwell Bridge Road Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. 27. 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 2009 Glen Burnie, MD Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 . Signature of Function Se vice Licensee Michael J. Flagle nter the pisease, shock, or heart failure. I is complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Glioblastana multiform disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transi Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 4 Pregnant
9 Unknown Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ribrovascular accident 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director. Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certify 29d, Date signed (Month, Dav. Year) R149194 Man CRNP August 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar St

Towson.

21204

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32. Registrar's Signature

Grant

31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760%

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filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Exeminer court be refilled at	ted	A1	15. Decedent's	Education			dent's Usual Occu			16b. Kin	d of Busin		
hin 7: e. Andi	Completed	(Speci		grade completed) College (1-	-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of wor ed)	king				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Examiner in at be refilled at once.		21. Signature of Fu		cifyth tombme	ent Ber		EMOY1AL ( 2. Name and Addre		./2009   :Comas F				ryland D A
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate be within 24 hours after death. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	þ	Part II. Other signif	icant condition	s contributing to de	ath but not resu	ulting in the u	nderlying cause gi	ven in Part I.		tobacco us Yes 2 [		te to the	e cause of death?
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0 4 × 0		29b. Signature and	'Anua	- Mey	rel.		29c. Licen	955	6	29d. Date	signed (M	700	7 .
4		30. Name and addre	ess of person w	Mujo	inid	6130	Landover	Road, Ch	neverly,	MD :	20785		
Sta Registr		31. Date filed (Mont	th, Day, Year)	2009	gistrar's Signa	ture.	barker						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician August 2009 Stewart <u>James</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes HUSPITAI 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🕱 M 2 🗆 F 212-05-8177 Director 90 April 14. 1919 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Ln. RGT 418 USA 21228 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify. WW II Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If flem 27 is marked other thr any Injury or other traumatic event, Ital. Vice President Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Stewart Nellie ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie S. Kolb (Daughter) 121 Harwood Rd., Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 9/1/09 4 ☐ Donation 5 ☐ Other (Specify) |Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNKNUNA myocardia disease or condition resulting in death) /Medical Due to (or as a it insequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by valvular disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes 2 - No Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manper of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation within 24 hours after occur.

To the Funeral Director: After the Funeral Director of the funeral or the funeral 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, SEP 0 1 2009

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Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., g895,09/01/09dhb trar Certificate of Death Reg. No. For A State Registrar Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 12:55 AM em ENNIS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 119 Philadelphia Road Baltimore County Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) March 11 1948 6. Sex 7. Age (In vrs. last birthday) **Funeral 1** M 2 □ F Months Days Hours Min. 216 54 3627 61 Baltimore,Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examination at once. Director 1 ☐ Yes 2 ☐ No Marvland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Kearney Drive 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:**Vietnam** 1 □Yes 2**X**□No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Instrument Technician BG & E 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Semenkow Genevieve Thomas ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1610 North Bend Road Jarrettsville, Maryland 21084 Lori L. Huesman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State St Joseph Ch. Cemetery. 9/3/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc HO 7401 Belair Road Baltimore, maryland 21236 23a. Part 1. Enter the dise or complications that cause Durnut enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CLAS /Medical Due to (or as a consequence of): Examiner arringen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Yo the Funeral Director: After this certificate has been signed by the attending physician and about the Puneral Director: After this certificate has been signed by the attending physician and about the Puneral Director, page 2 should be detached for use as the burlan-transit Exam Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Brother's Injury at 28d. Describe how injury occurred Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W

Registrar

31. Date filed (Month, Day, Year) SEP 0 1 20

SEMENKOW

ENNIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 UGU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTE if Under 1 Year | If Under 24 Hrs. | 8. 6. Sex 1 M 2 □ F Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Davs 179-28-282 March 36, 1935 Director PA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State in than "natural", or items 23a or 28a-f show 1 Downer 2 No MD Baltimore Dundalk Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 8223 Peach Orchard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Crain Operator Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Ankrom Joseph Skelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8223 Peach Orchard Rd, Dundalk, MD 21222 Denise Herring-Daughter 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ X remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8-31-09 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Eugeral Service Li PA, 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** 18 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical use as the aftending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) I □ Yes 2 □ No Ö the detached 9 Unknown 9 Unknown þ О. s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed disease & Cormary 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 1 □ Yes 2 □ 2 🗆 No 1 ☐ Yes of Vital Kabetes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation (Month, Day, Year) Division Hospital or Attending ours after death.

neral Director; A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

4940 32. Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

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Battimore, MID

Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** 8 12 abu 4a. Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltomere Viercu Center More If Under 24 Hrs. 5. Social Security 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, **Funeral** Days Hours Months Min. 1 ☐ M 2 📜 F Director 33 2009 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f show event, the Medical Examiner must be notified at Director TIMORE more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Funeral 21244 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2. No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) NA NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 mar Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other traionce. Sherrap mothe timore Smith 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Desurial 2 ☐ Cremation 3 ☐ Removal from State -05 3 4 ☐ Donation 5 ☐ Other (Specify) Ballo 21. Signature of Euneral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory must shock, or heart failure. List only one cause on each line. Immediate Cause (Final ..Physician disease or condition resulting in death) -x+reme tremati /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): physician a Box 68760, Physician/Medical signed by the attending I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2 No o 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 🗌 Yes certificate has been s ector, page 2 should Certification: To Be Completed + Membrane 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes reral Director: A 2  $\square$  No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the 29c. License number 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

> H. PA 2,232 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tohacco use contribute to the cause of death? 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) Baltimore 21202

Year

2009

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Birthplace (State or Foreign Country)

10d. Inside City Limits

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MO 21244

1XYes 2 No

Maryland

State Registrar

Date filed (Month, Day,

Year)

-

DHMH 17 Rev 1/2001

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Place

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nora C. Sizemore August 25 2009 5:35 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel County Glen Burnie Glen Burnie Health and Rehab. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24 1909 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Days Hours 415-16-2520 100 Tennessee Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eventhan must be neathed. 10a, State 10c. City, Town or Location 10d. Inside City Limits ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland 1 4 1 Anne Arundel Pasadena 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 114 Clover Hill Road 21122 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Fiver in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Mever Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Tennessee 8 0 Nurses Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Cooper Louise Ballard ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O. Jeannette Murphy 114 Clover Hill Road, Pasadena, Maryland 21122 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 29-09 Cedar Hill Cemetery Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest stock, or heart failure. List only one cause on each line. Im a diate Cause (Final disease or condition resulting in death) MYO constat WithneTION **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 I No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

burial-trai

as the

use

for

the attending physician

signed by

Baltimore, Maryland 21215-0036

Certification: To 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

2. Registrar's Signature

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Year)

State Registrar

completely filled in by the funeral director,

within 24 hours a To the Funeral D

9-06556 Jerry T. Thomas	Please Type or Print in Black Indelible Ink. Ensure All amend #5 Per State G8 War Ward / ODep Hitment of Health and Mo	Copies Are Legible. ental Hygiene
Physician	1- For State Registrar Certificate of Death 1. Decedent's Name (First, Middle,Last)	Reg. No. 2009 2095
Medical Examine		Month Day Year 2259 hrs
	4a. Facility Name ∮f not institution, give street and number) 4b. City, Town, or Location 4551 Finney Avenue  Baltimore	on of Death  4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If U	nder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	217-66-7812 4xk 1XM 2 F 54 Yrs.	Nov. 20, 1954 Foreign Country) Md.
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	Md. NA Baltimore	1 X Yes 2 No
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  To no other traumatic event, the Medical Ex. miner must be notified at once.	10e. Street and Number	10g. Citizen of What Country?
with th	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic	
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ours after		ve kind of work done 16b. Kind of Business/Industry
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Media	Tr. Father's Name (First, Middle, Last) Welder	her's Name (First, Middle, Maiden Surname)
1215 I be file ental H arked o	Bl. Nathan Ihomas ITo	annie Mae Hall
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mec	19a. Informant's Name/Relationship (Type, Print) (niece) 19b. Mailing Address (Street and MS Lake Sha Howard 2515 Druid	Number of Rural Route Number, City or Town, State, Zip Code)
re, N : 1 and ! Health f item	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite Important: If ite Injury or other tr	4 Donation 5 Other Specify: GreenMount Crematory	19/1/2009 Balto. Md.
Baltimo permit. Page Department of Important: injury or off	21 Signature of Funeral Service Licensee 22 Name and Address of Fa	Es Funeral Home, P.A.
Physician	23a/Part I. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.	s cardiac or respiratory arrest, shock, or heart  Approximate Interval  Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Narcotic & cocaine intoxication  Due to (or as a consequence of):	Dooth
	Sequentially list conditions,  b.	
ted nsit	Due to (or as a consequence of):  cause. Enter Underlying Cause (Disease or injury that initiated	
ted Insit		
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box 68760, the death certificate be toy the attending physicisched for use as the burial Dhysicisched for use as the burial physicisched for the purial physicisched for the phys	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	23d. Date of delivery
ox 68 th certi	past 12 months?  1 Live birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Other (Specify)	opic pregnancy Month Day Year
D. BC the destroy the a suched for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I, 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burier of or the funeral director.		1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, spital or Attending Physician: The law requires near a Director. After this certificate has been signifiled in by the funeral director, page 2 should be Contributed.		24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of
tal Rec		performed?   death?   1 Yes 2 No
/ital	1 examiner?	th (Check only one)  Nursing Home 5 Residence 6 ✔ Other: Scene
of Vit ing Physic After this c funeral dire	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at W	I 1
Sior Attend r death ector; by the	Pending 2 Accident 5 Pending Investigation Investigation 2 Re. Place of Injury - At home, farm, street, factory, office building	
Division o  Division o  Spital or Attending  spital or Attending  nours after death.  neral Director: After  filled in by the fune	Suicide 6 X Could not be determined (Specify) found at home	, etc. 28f. Location (Street and Number or Rural Route Number, City BAT Lovin State) 4551 Finney AVe
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the		
To the Ho within 24 To the Fu completel	and manner stated.  29b. Signature and title of certifier  29c. License numb	
	0.C.M.E.	August 22, 2009
$\phi$	30. Name and address of gerson who completed cause of death (Item 23a)	- ND 04004
Stat	Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	3, IVID 2 120 1
Registra	SEP 0 1 2009 Senson 12. 4 and	

1 - For State Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 **Physician** 26, 8:50 а м Thompson Aug. Jane /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1080 E1m Rd Halethorpe Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 □ F 88 June 3, 1921 Maryland 215-22-2239 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2√ No Baltimore Halethorpe Maryland by Funeral Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Evan Instrust being once. USA 1080 Elm Rd. 21227 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify. 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathanie1 Clagett Perry Belle Deater Annie ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois C. Thompson (Daughter) 1080 Elm Rd., Halethorpe, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 18/28/09 Baltimore, Maryland -22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Approximate Interval Between Onset and Death 23a. Parf T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical bolic steat hepati Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed P.O. Box 68766, Co Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Non-insulin dependent maketes melling 23e. Did tobacco use contribute to the cause of death? Records, ģ 20 No 3 Probably 4 Unknown 1 Tes certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Division of Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 1 Yes 2 No Certification: To 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and the of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md. 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

amend 15tate 30 Marylandy 15895 then 1 09 Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar

Linda Rosenthal 6565 North

31. Date filed (MontSEP

Charles St. Towson,

gistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland / [		ment of F ficate of i		l Mental Hy	giene Reg. No. 2	2009	27956
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	Year	3. Time of Death
de de	Physici /Medi			Tacket					August	29, 2	009 <sup>Tear</sup>	7:45 A <sup>M</sup>
Jan.	Examir	ner	4a. Facility Name (If not institution,					r Location of De	ath		unty of Death	
	Funeral		8100 Connecticu  5. Social Security Number		ge (In yrs. last bir		nevy Ch Under 1 Year	ase   If Under 24 Hi	rs. 8. Date of Bir	th	tgomery 9. Births	place (State or Foreign
	Director		410-74-1907	1 XM 2□ F			onths Days	Hours Mi	Apr 12	ay, Year) 1921	Tenne	ntry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Locatio	on.				11	I0d. Inside City Limits
	r the Maryland r 28a-f show notified at	jo		ma								1 ☐Yes 2 XNo
	or 28a	irec	MD Montgo	пету	Chevy (		Of. Zip Code		T	10g. Citizer	n of What Cour	ntry?
	feath with ms 23a of must be	ralD	8100 Connecticu	t Avenue Si	uite 210	:	20815			USA		
La	72 hours after death with the Maryland natural", or items 23a or 28a-f show dicel Examinet must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🏿 Marrie	12. Was Deceden Armed Forces 1 XYes 2	?	13. Was	Decedent of H s, specify Cuba	lispanic Origin? an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	)- 14.	Race - Americ Black, White,	
036	urs after d al", or iten Exeminer	by [	3 ☐ Widowed 4 ☐ Divorced	IA Von Civo	1945–47	10	Yes 2⊠No	Specify:		Sp	ecify: Whit	ce
5-0	72 hours natural", dien Exp	eted	15. Decedent's (Specify only highest		16a.	. Decedent	's Usual Occup	ation during most of w	orkina	16b. Kind	of Business/In	dustry
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or		ife. DO I	NOT use retired	d)		Healt	haaro	
d 2	filed in Hygid	Be Co	17. Father's Name (First, Middle, La		EIIŽ	YSICIO	311	18. Mother's N	ame (First, Middle			
/lan	Mental Mered of arked of attc eve	To B	John Otis Tacke	t				Lucille	Sanford			
lar)	d 2 should be filed within 72 hou th and Mental Hygiene. 7 Is marked other than "natural traumatic event, the fraction E	Ė	19a. Informant's Name/Relationship		1	-			Rural Route Numb			Code)
e,	l an Heal		Lynn Kinch/daugl	nter					evy Chase		20815 ion - City or To	own State
Baltimore, Maryland 21215-0036	Pages ment of ant: If ite ury or o		1 ☐ Burial 2 【XCremation 3 4 ☐ Donation 5 ☐ Other (Spe				n (Name of bry or other place ney Crea		08/31/09		•	
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of uneral Service Line	to the	MO1251				ion Servi			784 a, MD 21029
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that cause							NSVIII C	Approximate Interval Between
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	/Medical Examiner		resulting in dealth)		a consequence or ascular	•	250					
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687	tificate ng phy as the	ledical		a								
Вох	death certiff e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □ Ec	topic pregnanc	у		23d	l. Date of delive	ery Day Year
0	0 0 T	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of death	5 □ Oti	her (specify) _				WOTH	Day rear
o,	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant condition	s contributing to death	but not resulting in	n the under	lying cause give	en in Part I.	23e. Did 1	obacco use	contribute to ti	he cause of death?
ord	w require been signature should b	ted k							_ 1 🗆	Yes 2 🛣	No 3□ Prot	bably 4 Unknown
of Vital Records,	elaw n hasb	Completed	***************************************						24a. Was auto	osy	prior to co	ppsy findings available impletion of cause of
a	ag ag		OF West and the second					Company Co	1 □ Yes		death? 1 ☐ Yes	2 □No
Z	iysicla iis cert directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1  Innat	ient 2 ☐ ER/Ou	itnatient 3	Othe		eath <i>(Check only c</i> Home 5 <b>X</b> Resi		Other (Specif	6.1
n 0	Attending Physician: r death. ector: After this certifice by the funeral director, p	J:UC	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of In	ury 28b. 1	Time of njury	28c. Injury Work		28d. Describe			(9)
Sio	Attendil death. ctor: A y the fu	catic	2 Accident investigat 3 Suicide 6 Could no	ion			M 1 🗆	Yes 2 ☐ No				
Division	al or Al s after c al Direc ed in by	Certification: To	4 Homicide determine	20e. Place of it	jury - At home, far tc. (Specify)	rm, street, 1	factory, office		28f. Location ( City or To	Street and N wn, State)	lumber or Rura	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier (Check only one)  1 Certifying 2 Medical Ex	Physician: To the best taminer: On the basis and manner s	of examination an	e, death oco	curred at the tir igation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) ar date and pla	nd manner as s ace, and due to	stated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier		0		29c. License				igned (Month,	
	CXI		102	el Row	No	-	D0983	4		August	31, 2	2009
0	12, 1		30. Name and address of person with Rarry N. Rosenba						MD 20	905		
	Sta	te	Barry N. Rosenba		rar's Signature	agut	Ave. Ke	ensingto	MD 20	895		
	Registr		SEP 01	2009	. 1	ha	al I					

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year UMSTEAD) 20:15 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Sa If Under 1 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 76 162-28-5459 Sept. 3, 1932 Pennsylvania Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits Forest Hill Harford 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Montgomery Drive 21050 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waldenbooks Store manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola May Rose Wesley Wayne Mohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Umstead-son 2106 Spindletop Drive-Murray, Kentucky 42071 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Evans Funeral Chapel 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State and Cremation-Bel Air Sept.1,2009 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel 3 Newport Drive and Cremation Services Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lutracranial 48 hrs disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ulminary. Due to (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death?

Physician \* /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amortant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amortant: Just by Marital Experiment, wet by any injury or other traumatic event, the Marital Experiment, wet by any july once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

Completed by

Be

2

e Hospital or Attending Physician: The law requires that the death certificate be executed the born state death.

A hours alrector: After this certificate has been signed by the attending physician and letely filled in by the furneral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

Exami Physician/Medical þ Completed Be

Medical

IF FEMALE: Certification: To

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

> 29a. Certifier (Check only one)

25. Was case referred to medical examiner? 5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Inpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

1 ☐ Yes 2 🗙 No

24a. Was an autopsy perforn

1 ☐ Yes

26. Place of Death (Check only o e)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

Simonx

Manas 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

To the I within 2

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

osa Vasquez	1.	For State	Sta	ate of Ma	aryland	/ Depar	rtment of dificate of	Health and	Mental H		eg. No.	21	109	2795
Physician	Re	egistrar Decedent's Name	(First, Middle	e,Last)		- Cert	incate of	Death		2. Date of Dea	th	Year	3. Time of I	
ledical Examine	r			R		. VASC	QUEZ		Location of Death	Month August 27	7, 2009	County of De	0930 h	irs
	4	a. Facility Name (if Washington			and number	r)	1	ib. City, Town, or Takoma Pa	rk		М	ontgomery	/	
Funeral	5	. Social Security Nu		6. Sex	7. A	ge (In yrs. Ia	st birthday)	If Under 1 Yea		_	rth(MM/I	For	Birthplace (Stat	
Director		219-31-09	980	1 M 2	X F		41 Yrs	Months Day	s Hours Min	Decemb	er 9	,1967	Country)E1	Salvado
ź.	-	Jsual Residence of 0a. State	Decedent 10b. County			10c. City,	Town or Locat	ion					10d. Inside	City Limits
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larylan	인도	0e. Street and Nun	nber					10f. Zip Code			-3	zen of What C	-	
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death with the Maryland or items 23a or 28a-f show must be notified at once	a. I	Marital Status     Never Marrie	ed 2 <b>x</b> M	۸.	med Force		If Y	es, specify Cuba	n, Mexican, Puert	o Rican, etc.)	i	White, etc		
fter de	a -	3 Widowed		orced If Yes, or Date	Give Year	2 <b>x</b> No			specify: Sa			Specify: W		
hours a		15. Decedent's Ed Elementary/Seco			est grade c		16a. Deceder during m	nt's Usual Occupa nost of working life	ation (Give kind of e. DO NOT use re	tired)	100.1	Ciria of Basilio	osomicustry	
36 hin 72 e. than "	ompleted	7th	ridary (0-12)		mogo (1 4 c	<i>x</i> , σ.,	House	keeper			1 -	wn HOu	se	
1215-0036 Id be filed within 72 hours after fental Hygiene, narked other than "natural", event, the Medical Examine:	ပ၂	17. Father's Name	(First, Middle	, Last)	Unkr	OM			18.Mother's Nam	ne (First, Middle ia Vasq		Surname)		
	B B	19a. Informant's Na	me/Relation	ship (Type, Pr			19b. Mailir	ng Address (Stre	et and Number or	r Rural Route N	umber, C	city or Town, S	State, Zip Code	)
MD 2 d 2 shou lith and lith an	-	Javier C			(hus	sband)			e Hyatts	ville,			ty or Town, Sta	te
re, s I an f Hea If iter		20a. Method of Dis		n 3 Rer	moval from			sition (Name of c ther place)					pring,	
Baltimore, permit. Pages I an Department of He Important: If ite	- 1	4 Donation 5 21. Signature of Fu	Other S	oecity:		/ Ga	te of l	Name and Addre	emeteSep ss of Facility Sa	nta Cru				
Baltimo permit. Page: Department o Important: injury or oth	(	Dans	2/1/2/	9 /28	Hu	te	60	00 Kenne	dy St, N	W :Wash	ingt	on, DO	20011	
Physician	7	23a. Part I. Enter the failure. List or	ne disease, o	or complication	ns that caus	sed the death	n. Do not enter	the mode of dyin	g, such as cardiad	or respiratory	arrest, sh	nock, or heart	Approx Between	imate Interval en Onset and Death
Medical examiner	1	Immediate Cause or condition resulti	(Final diseas	<sub>e a.</sub> Ca	rdiac	arrh	ythmia							
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	ije	if any, leading to it cause. Enter Und	mmediate		(or as a co	onsequence	of):					V2-1		
- 4	Examiner	(Disease or injury events resulting in			(or as a co	onsequence	of):							
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<b>60,</b> are be e hysicial e burial	Medi	IF FEMALE:		230	16	tcome of pre		go90 1.	2/10/09		2	3d. Date of d		Year
687 sertifica nding p	lan/	23b. Was deceden past 12 month		the 1	Live birt Pregnar	h nt at time of c		Fetal death Other (Specify)	3 Ectopic pre	gnancy		Month	Day	Teal
Division of Vital Records, P.O. Box 68766 tal or Attending Physician: The law requires that the death certificate is after death.  "In Director: After this certificate has been signed by the attending phy led in by the funeral director, page 2 should be detached for use as the b	Physician/M	1 Yes 2	No 9 L	Inknown 9	Unknow					220 D	id tobaco	o use contrib	ute to the caus	e of death?
bat the ed by t	by P	Part II. Other sign	nificant cond	ditions contr	ributing to o	leath but not	resulting in th	e underlying caus	ie given in Part I.				Probably 4	
duires a	ted	V. <del></del>								24a. V	Vas an utopsy	24b. W	ere autopsy fin	dings available
COFC	ompleted									_   _ p	erformed es 2	i? de	eath?	2 No
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Vita hysicia this cer	o B	examiner? 1 <b>✓</b> Yes	2 No	Hospit	- '		ER/Outpation		Other Nu	ursing Home 5		idence 6 injury occurre	Other:	<del></del>
n of ding Pl	on: T	27. Manner of De 1 X Natural		ending	28a. Date o (Month, I	f Injury Day,Year)	28b. Time		Yes 2 No					
Siot Attenor or death rector: by the	icati	2 Accident	In	vestigation	28e. Place	of Injury - At	home, farm, s	treet, factory, office	ce building, etc.		on (Stree		er or Rural Rout	e Number, City
Divis pspital or A pours after meral Dire	Certification:	3 Suicide 4 Homicide	de	ould not be etermined	(Specify)								The state of the s	
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only one) 2		Physician:	To the best	of my knowl f examination	edge, death oo n and/or invest	curred at the time igation, in my opii	e, date and place, nion, death occur	and due to the red at the time,	cause(s) date and	) and manner I place, and di	as stated. ue to the cause	(s)
To the Ho within 24 To the Fu completel	Medical	29b. Signature of		and	manner sta	ated	1/25		ense number				ed (Month, Day	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10AM Physician /Medical ty Name (If not inelitution, give street and number) Town, or Location of Death 4c. Countý Examiner elaus timo 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 219-28-8530 1 X M 2 □ F Months Days Hours Min. Director June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In. Medical Ereni, in. 1, and burnal may any injury or other traumatic event, In. Medical Ereni, in. 1, and burnal may any injury or other traumatic event, In. 10b. County 10d. Inside City Limits 10a. State City. Town or Location **Funeral Director** MOR 1 ⊈Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code hens Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ecora 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number idos 121216 20b Place of Disposition (Name of completely grematory or other p Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rema 21. Signature of Funeral Service Licensee 22. Name like 23a, Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line.

Trunc date Caus (Final dic ase or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day, Year) 27 Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 🗖 Natural 5 Pending 1 Tyes 2 No 2 Accident investigation Director: 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

P.O. Box 68760 Division of Vital Records, e Funeral I To the

> State Registrar

(Check only one)

29b. Signature and title of

30. Name and address of

Jest

on who completed cause of death (Item 23a) (Type, Print)

2000

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BAHIMORE STREET BAHIMORE

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:45 AM Medical not institution, give street and number) or Location of Death ty of Death **Examiner** awson 105 Altimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. **Director** sidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 28a-f 1 X Yes 2 ☐ No 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. 1 Never Married 2 Married ō ò 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life 100 NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha Be Name (First, Middle, 18. Mother's Name (First, M ည 19b. Mailing Address (Street and Number or Rural Route Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition Place of Disposition (Name of cemetery, crematery or other Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Funeral Service Licensee nature er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, leart failure. List only one cause on each line. Approximate Interval Between hock, or l Immediate Cause (Final Onset and Death 04 Complications Ovarrian Physician/ isease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No jo Day Year Pregnant at time of death 5 Other (specify) should be detached 9 Unknown Hnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 • Hospital or Attending Physician: The 24 hours after death.
• Funeral Director: After this certificate by 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital. Other: 2 X No ၉ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident Investigation 1 Yes Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examines. On the basic of oxidimators and stated and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I 29b. Signature and title of certifier R149194 Angust 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grant Sh . (harles 101 Touson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2009

Registrar

Michael White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 27961

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Physicia	n/ 1	Decedent's Name (First, Midd	dle,Last)	1 311	17-		0	2. Date of Death Month Day August 27, 20	Year	3. Time of Death 1444 hrs
Medical Examir		a. Facility Name (if not instituti	ion, give street and number)	WHI		City, Town, or L	ocation of Death	August 27, 20	4c. County of Deat	1
Funeral	5	University Hospital  Social Security Number	6. Sex 7. Ag	ge (In yrs. last bir		Baltimore If Under 1 Year	If Under 24Hrs.	8. Date of Birth (M	M/DD/YYYY) 9. Bi	rthplace (State or
Director		219-06-5552	1 M 2 F	24	Yrs.	Months Days	Hours Min.	11/01/19		Duntry) MARYLAND
any	_	Usual Residence of Decedent  Oa. State 10b. County	у	10c. City, Town	or Location	1				10d. Inside City Limits
	<u>5</u>	MARYLAND N	U/A	B		MORE  10f. Zip Code		10g. (	Citizen of What Cou	43
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygene tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Funeral Director	0e. Street and Number	UCHESTER S	St., APT	·K	210		6	1.S.A	?
h with tl ems 23a	eral	11. Marital Status 1 Never Married 2	12. Was Deceden Armed Forces	t Ever in U.S.	13 Was	Decedent of Hisp s, specify Cuban,	oanic Origin? ( Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
fter deat !", or ite			1 Yes 2 Divorced If Yes, Give Year	2 × No	L	Yes 2 ¥ No			Specify: 13	
hours af natural Examin	ed by	15. Decedent's Education (Special Control of the Co			Decedent's during mo	s Usual Occupati st of working life.	on (Give kind of w DO NOT use retir	ed)	b. Kind of Business	
136 thin 72 ne r than " ledical ]	ompleted I	Elementary/Secondary (0-1)	2) College (1-4 of			1ABON		(First, Middle, Mair		AGENLY
15-0036 filed within 7 il Hygiene ed other than t, the Medics	Be Cor	17. Father's Name (First, Midd	(SLOVER	4	HITE		RENIA:	TA	KELL	
2121 hould be find Mental I is marked tic event,	To B	19a. Informant's Name/Relation	onship (Type, Print )	_				Rural Route Numbe	r, City or Town, Sta	te, Zip Code)
e, MD 21215-003 t and 2 should be filed within Health and Mental Hygiene item 27 is marked other the traumatic event, the Mec	-	20a, Method of Disposition	114 (mor	20b. Place	of Disposi	tion (Name of cer	metery,	Date 2	0c. Location - City	
Baltimore, permit. Pages I an Department of Hos Important: If ite		1 X Burial 2 Cremat 4 Donation 5 Other	Specify:	State Crem	FON S	tax Cemer	ERY 09/	03/2009	BALLIMO	RE, MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death will Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be.		21. Signature of Funeral Servi	rice Licensee	Main	22. N	ame and Address	of Facility BROW  STON A	NI JR. F	UNIERAL	HOME MD 21317
Physician		23a. Part I. Enter the disease, failure. List only one cau	, or complications that cause	ed the death. Do	not enter th	e mode of dying,	such as cardiac o	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
/Medical aminer		Immediate Cause (Final diseasor condition resulting in death	<sub>ase a Multiple Guns</sub>							300
		Sequentially list conditions,	b. Due to (or as a cor							-
	Examine	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate	use c.							
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Sox 68760, death certificate be cattending physic for use as the bur	ian/Med	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the 1 Live birth		2 Fe	tal death 3	Ectopic pregr	ancy	Month	Day Year
Box 68760 e death certificate b the attending physi ed for use as the bu	ysici	1 Yes 2 No 9	Unknown g Unknown	1	J 0	her (Specify)		23a Did toh	acco use contribut	e to the cause of death?
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rds, Frequires	eted							24a. Was a autops	y prior	e autopsy findings available to completion of cause of
(ecol	Completed							perform 1 <b>Y</b> Yes 2		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law require as after death.  Director: After this certificate has been sivel in by the funeral director, page 2 should be comed in by the funeral director, page 2 should be	Be C	25. Was case referred to me examiner?	Hospital: 1 Inp	atient 2 V EF	R/Outpatien		Other Nurs		Residence 6	Other:
of V ng Phys After thi neral di	n: To	1 Yes 2 No 27, Manner of Death	28a. Date of (Month, D. Aug 27, 20	Injury 2	3b. Time of 405 hrs	Injury 28c. In	jury at Work? Yes 2 ✔ No	28d. Describe h Subject shot	ow injury occurred	
ivision  or Attendi after death.  Director: 4	catio	2 Accident	Investigation 28e. Place of	of Injury - At hom						or Rural Route Number, Ci
Divi	Certification:	4 V Homicide	determined (Specify)	Local Street					nont Street , Balt	
Division of Vital Records, P.O. Box 68760, To the Ilospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici or her Funered. The fineral director, page 2 should be detached for use as the burit	Medical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the best of I Examiner: On the basis of	examination and	death occu or investiga	urred at the time, ation, in my opini	date and place, a on, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	to the cause(s)
To the comple	Med	29b. Signature and title of co	and manner sta	ted.		29c. Lice	nse number		29d. Date signed August 28, 2	(Month, Day, Year)
		Pari (	h-roll	<i>ا</i> ر ا	30)	0.0	С.М.Е. 		August 20, 2	
•		30. Name and address of per Patricia Aronica-P		of death (Item 2 nt Medical Ex	kaminer	111 Penn	Street, Baltim	ore, MD 2120	1	
	State		Year) 32 Reg	istrar's Signature	har	Ked				
Regi		SEP U.	1 - COO3 - Kenne	and free	ORIGIN					

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State of Maryland / Department of Health and Mental Hygiene 6

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Allen Hoyes Wordlaw 0407AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Batimore Botimore VA Medical Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State pr Foreign 7. Age (In yrs. last birthday) **Funeral** 62 Yrs. Days Months Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shov event, the Modeal Exeminer must be notified at 1 Ses 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ØYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itel Black White etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO DOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) reakman d 18. Maner's Name (First, Middle, Ma Be ပ္ Name/Relationship 19b. Mailing Address (Fireet and Number or Fiural R) te Number, City or Town, State, Zip Code) 1/c 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1 Burial 2☐ Cremation 3☐ Removal from State 4 Dopation 5 Dother (Specify) 21. Signature Juneral Service Lice 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ned ate Cause (Final dises se or condition red lting in death) **Physician** Due to (or as a consequence of): hemorrhage /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ed by the a detached f 1 □ Yes 2 □ No. 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> icate has been sig 7, page 2 should b myelodysplastic syndrome 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 □ Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 ☐ Pending investigation r death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Thomicide ō 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 8/27/2009 and address of person who completed cause of death (Item 23a) (Type, Print) 10 N Greene St Bultimore, MD 21201 Titlany M Frozee, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:40 p M 2009 28 Bernard A. Wright August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ellicott City Health and Rehab Center Ellicott City
1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 14, 1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 3 M 2 □ F Months 78 Director Maryland 214-26-0214 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, I'm Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Baltimore Maryland Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code death with 410 Waveland Road United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No Specify Specify: White 3 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard A. Wright, Sr. Katherine G. Biggs ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Wright/Wife 410 Waveland Road, Catonsville, Maryland 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and Department of He Important: If Iten any injury or oth once. 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. Baltimore, Maryland 21. Signature of Funeral Service Lipensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of) Examiner EVER Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi DISEASE O RONARY ARTENY Due to (or as a consequence of) physician sthe burial P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 2010 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۴ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

h State

Registrar

DHMH 17 Rev 1/2001

96505 ANTIAGO Rá Suite 110 COlumbre 31. Date filed (Month, Day, Year) 32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Speak MO

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MO

(SHAKUNMACA GUPTA ND)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 9101 **Physician** WayKer William 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death Examiner Memoria Battimo 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1 ☐ M 2 ☐ F Months Days 49 86-381 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Nes 2 No Director yaryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) *Yarsons* Geneva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License evir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** /Medical 10 days Due to (or as a consequer ce of : Examiner esente if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician al s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 s autopsy performed? After this certificate I funeral director, page 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check onli one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 ☐ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESIDENT Jonathan. 30. Name and address of person who completed of ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	Pwr <sub>State</sub> of Mar	-		nt of Health te of Death			ene a. No	000	07065
		Decedent's Name (First, Middle,	Last)					2. Date of Death	2.00	<del>U U 3</del>	3. Time of Death
Physicia		Chewell. Re	heer Re	becca	Yewe1	L		Month Aug 3	Day 7	Year	3.45 A M
/Medic Examin		4a. Facility Name (If not institution,	. /			Town, or Location	2.			unty of Deat	
Funeral Director		5. Social Security Number 2/9 30 500		In yrs. last birti	hday) If Under Months		Min.	B. Date of Birth		9. Birt Co	hplace (State or Foreign untry)  NC
and *	ŀ	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	or Location						10d. Inside City Limits
f ehc	5	MD		RAT T	IMORE						1 <b>X</b> Yes 2 □ No
the 28a	Director	10e. Street and Number		DAUL		p Code		10	a. Citizen	of What Co	untry?
3a or		4504 REISTERS	STOWN ROAD			21215			US	SA	•
be filed within 72 hours after deeth with the Maryland ital hygiene. of other than "naturel", or iteme 23s or 28s-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marrier  3 M Widowed 4 Divorced	12. Was Decedent Evi Armed Forces? d 1  Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Deci If Yes, sp	edent of Hispanic Or early Cuban, Mexica 2X No Specify	ın, Puerto Ri	rfy Yes or No- can, etc.)	14.	Race - Ame Black, White ecify:	nican Indian, e, etc.
rithin 72 h ne. han "natu • Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)		life. DO NOT	ork doné during mos use retired)	st of working	7		of Business/	·
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2 should be filed within and Mental Hygiene. ie marked other than aumatic event, the Ma	To Be	17. Father's Name (First, Middle, La  NED T. EDMONI		1			·	First, Middle, M. STATON	aiden Sui	mame)	
ges 1 end 2 should be tiled within 72 hours at to Health and Mental Hygiene. If item 27 ie marked other than "naturel", or or other traumatic event, the Medical Exam		19a. Informant's Name/Relationship			-	s (Street and Numb					
1 end 1 Health em 27		SALLIE MARROW  20a. Method of Disposition	-		Disposition (Na	LDSPRING	LANE	BALTIMO			Town, State
Pages 1 er		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	B □Removal from State	cemetery	y, crematory or	other place) CEMETERY	9-5-2	1		IMORE	
permit. Pages 1 en Department of Heal Importent: If Item 2 eny Injury or other		21. Signature of Funeral Service Li	iensee 7. Morto	'n		nd Address of Facil		ES A. MO	RTON	& SO	NS F.H., INC
Physician /Medical		23a. Part1. Inter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a Core	diac o	irrythe		s cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death IS MM (0)
Examiner		Sequentially list conditions,	b. Qthe	ruscle		hoom Lall	soate	,			15 4-5
outed id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	eonsequence o	,						2045
Par is	dicai Ex	resulting in death) Last	Due to (or as a c	moinh q	of):	-					154-3
	edi										
et the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tim 9□Unknown	Fetal death	3 □Ectopic p 5 □ Other (s				23d	. Date of del Month	ivery Day Year
es ti	<u>م</u>	Part II. Other significant condition	s contributing to death but r	not resulting in	the underlying	cause given in Part	1.		2 N	•	o the cause of death?
The law re ate hes bee page 2 sho	Completed							24a. Was an autopsy perform		4b. Were au prior to death?	utopsy findings available completion of cause of
icien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Plac	e of Death (	Check only one			
Physic this ce al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient	2 🗆 ER/Out	patient 3 D	OA Other: 412N	ursing Home	5 🗆 Residen	ice 6	Other (Spec	cify)
		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	(ear) 28b. Ti	ime of njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		d. Describe how	v injury o	bernuoc	
tal or Attenus after death	Certification:	3 Suicide 6 Could no determine		- At home, far (Specify)	m, street, facto	y, office	28	f. Location (Stre City or Town,		umber or Ru	ural Route Number,
Hospi 4 hou Funer (ely fill	edical (	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the best of reminer: On the basis of examiner stated	kamination and	, death occurred Vor investigation	d at the time, date as n, in my opinion, dea	nd place, an ath occurred	d due to the cau I at the time, dat	use(s) and e and pla	d manner as ace, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	1.		29	c. License number		29	d. Date si	igned (Monti	h, Day, Year)
1		•	De-	* DES	A lan	D3040	94		81	18/09	
4	-	30. Name and address of person when the person with the person			Type, Print)	18 Colon	svile	mp 212	18		
Stat Registra		31. Date filed (Month, Day, Year)	716 Maic 32 Aegistrar's	Signature	barle	,				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** М August 15, 2009 12:55 Anstett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Waldorf Waldorf Center 9. Birthplace (State or Foreign Country)
PA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 7,1932 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 206-26-2000 77 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a State 10b. County 1 ☐ Yes 2 ☑ No Director MD Charles Hughesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with b. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" ~ 27 and injury or other traumatic eventage. 20637 7330 Denise Lane USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 XNo White Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Oil Company Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Anstett Lucy Anstett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Loretta Hurysh 7330 Denise Lane, Hughesville,MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 8/19/09 Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, and product of the complete of Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the ft. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 17, 2009

State Registrar

DHMH 17 Rev 1/2001

30 Name and address

12070 Och 21
Begistrar's Signature

Lieur B. Laure

ho completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 4:37 Robert Joseph Berlin August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 X M 2 □ F Director 363-52-6040 57 22, 1951 Michigan Nov. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner roust be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Chevy Chase 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23a or death with 4111 Rosemary Street 20815 United States Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy Injury or other traumatic event, The sonce. Elementary/Secondary (0-12) College (1-4or 5+) Director of 5+ Sales Software 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berlin Joseph Donald ဥ Marjorie Ann Harden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Jennifer Berlin / Spouse 4111 Rosemary Street; Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 8/18/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failurg. List only one cause on each line.

Immediate the experimental consideration of the considerati 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissase of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical e attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Ye ar 5 Other (specify) □Yes 2□No ned by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 □ Yes 2 ☑ No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death. Director: After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical ompletely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26259 08/12/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue; Bethesda, MD 20814 Ava Kaufman, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State AUG 18 2009 Registrar

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8/11/09

BERLIN

OBERT

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 13, 2009 **Physician** 4:15 p M Samuel Beall /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Washington, DC 77 577-42-1409 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Evanance must be notified at 1 ☐ Yes Ž No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20903 USA 9936 Cottrell Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) County Government Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 Is marked oth jury or other traumatic even Robert Samuel Beall Anna Linthicum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau 9936 Cottrell Terrace, Silver Spring, MD 20903 Joan H. Beall/Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 17, Aug. 1 2009 ₩ Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licensee MOD937 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a End-Stage Chronic Obstrucitve Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Severe Hypercapnia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Possible Cardiopulmonary Arrest physician and the burial-tran Due to (or as a consequence of) Physician/Medical as IF FFMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) hed by the a ☐Yes 2☐No 9 Unknown 9 Unknown certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Comfort Care 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2X No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ™ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending ours after death. ieral Director: # filled in by the fi 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

P.O. Box 68760 Division of Vital Records, Hospital or Attending Physician: 24 hours a

To the I within 2 10

> State Registrar

31. Date filed (Month, Day, Year) AUG 18

30. Name and address of person Nidhi Gill, MD

29b. Signature and title of certifier

29a. Certifier

(Check only one)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06675 State of Maryland / Department of Health and Mental Hygiene Helen E. Baker Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ August 26, 2009 1140 hrs **Medical Examiner** Helen E. Baker

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot Easton Easton Memorial Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number Foreign **Funeral** Days Hours Min. Months Country) Md 06-02-1943 Director 218-40-6456 M 2 X F Yrs 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Md. Caroline Preston death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number 6208 USA Bethlehem Road 21655 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify: 1 Yes 2 No specify: Black permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner minjury or other traumatic events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events and the minjury events events and the minjury events and the minjury events events and the minjury events and the minjury events events events and the minjury events eve If Yes. Give Year Divorce 3 X Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) American Original 21215-0036 11 Line Supervisor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Broadway Mary Be James 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD C. Cambridge, MD. 21613

Date | 20c. Location - City or Town, State Apt. Tina Pritchett /Daughter St 622 Race 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State LLC 09-08-09 Dover, De Crematory 1 22. Name and Address † Facility Direct Donation 5 Other Specify Signature of Funda Service b Bennie Smith Funeral Home Easton, Md. 21601 426 Dover St Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Hypertensive Death M-dical a Atherosclerotic cardiovascular disease with Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): complications Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): mine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exar and transi **23a,per EM g901** 23a,27,permE, g Physician/Medical X AMENDED X UNPENDED 7079 TT signed by the attending physician be detached for use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c, if yes, outcome of pregnancy IF FEMALE: Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ò 24b. Were autopsy findings available Completed 24a. Was an peen page 2 should prior to completion of cause of autopsy performed? certificate has 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical director Be Other<sub>4</sub> Nursing Home 5 Residence 6 Hospital: 1 Inpatient ER/Outpatient 3 DOA 2 this ို 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: X Natural Yes 2 1 Pending

Division of Vital

the Hospita or Attending Physician; funeral After ceath. 24 hours after ceath Funeral Director: the iq ui within 2. To the F

2

3

Medical

State Registra

Accident

Suicide

Homicide

29b. Signature and title of certifier

31. Date filed (Gatta Date )

29a. Certifier 1

120 30. Name and address of person who complete l'ause of death (Item 23a) Щ Assistant Medical Examiner Theodore M. King, Jr., MD.

and manner stated

32. Registrar's Synature

Investigation

Could not be

determined

**ORIGINAL** 

28e. Place of injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

August 27, 2009

29d. Date signed (Month, Day, Year)

or Town, State)

OCME

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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AUG 18 2009

Sirmormac

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

holia

Registrar's Signature

**ORIGINAL** 

29c. License number

0028035

Piscataway hd Suite 310 Clinton, Mc 20735

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 6:55 PM **Physician** Joseph Ρ. Bradley 2009 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CHARLES CIVISTA MEDICAL CENTER LA PLATA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 57 578 70 3905 Yrs 5-9-1952 Director Wash. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, it of Podical Examinations to notified at 1 TYes 2 □ No Director Charles Waldorf MD the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 20602 United States 4680 Prestancia Place #204 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ∑XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) DC Govt- OAG Elementary/Secondary (0-12) College (1-4or 5+) Paralegal 7 is marked other traumatic event, III Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Pages 1 and 2 should be in nent of Health and Mental Phillip Bradley Alice Randolph ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 4680 Prestancia Pl. # 204 Waldorf Md 20602 Veronica J. Bradley Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other plateritage Memorial Park Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/24/2009 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eriscoe-Tonic Funeral Home 2294 Old Washington Rd Waldorf, Md 20601 23a. P / t1. Enter the usclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cirrhosis **Physician** /Medical Due to (or as a consequence of): Examiner saguell 122 Tr Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ndrome, Dinhetes Hospital or Attending Physician: The law requires that the death certificate be executed 120 rato and burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy for 1 Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 ☐ Yes 2 14No 1 □ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | XNo 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0

Registrar
DHMH 17 Rev 1/2001

State

Bredley

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3328 OLD WASHINGTON RD, WALDORF, MO 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NIRMALADEVI JAYANTHAN, M.D.

AUG 18 2009

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 16 13:05P M AUGUST 2009 DANIEL RICHARD BUMB /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, NOV 11 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours 1 M M 2□ F 69 ΙΝ 308-42-0999 1939 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No BEALLSVILLE Director MD MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20839 19520 BEALLSVILLE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 1963 If Yes, Give 1965 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🗷 No WHITE Specify: ð Year or Dates: 1965 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PETROCHEMICALS CIVIL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOROTHEA MARGARET KLEITZ JOHN VALENTINE BUMB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20839 19520 BEALLSVILLE RD., BEALLSVILLE, MD 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun 19520 BEALLSVILLE RD., BEALLSVILLE, JANET BUMB / SPOUSE 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State FREDERICK, MD STAUFFER CREMATORY 8/18/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund 22. Name and Address of Facility viate Licensee. HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MINUTES a ACUTE MYOCARDIAL INFARCTION resulting in death) /Medical Due to (or as a consequence of): Examiner YEARS DIABETES MELLITUS Sequentially list conditions. sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine YEARS LUNG CANCER Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA 2 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

The law requires that the death certificate be executed Box 68760. 0 ۵. signed by Division of Vital Records, has

within 72 hours after death

h and Mental Hygie is marked other tl

Baltimore, Maryland 21215-0036

and the burialthe attending physician hed for use as the buria page 2 certificate this After death. filled in by

the Hospital or Attending Physician: 24 hours after death Funeral Director: the

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State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 18 2009

4 Homicide

(Check only one)

29b. Signature and title of certifie

29a, Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM DOOLEY, MD 9801 MEDICAL CENTER DR.,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c, License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20850 ROCKVILLE,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9 Elwood <u>200</u>0 Marvin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Jar 5. Social Security Mamber If Under 1 Year (State or Foreign Date of Birth (Month, Day, ge (In yrs last birthdav) **Funeral** Year) Months Days Hours 1 X M 2 □ F 218-16-2881 Yrs. 92 7, 1917 **Director** April Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be in Alfilad at 1 ☐ Yes 2 X No Director MD Accident Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 253 Aiken-Miller Rd. 21520 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify. White þ 3 XWidowed 4 ☐ Divorced n and Mental Hygiene. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 10 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be John Beitzel Rosa Stark ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 Is
any Injury or other trau Ronald E. Beitzel/Son 287 Sawyer Dr., Harpers Ferry, WV 25425 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 22, 2009 Bittinger, MD Bittinger Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Newman Funeral Homes, P.A. em P.O. Box 275, Grantsville, MD 21536 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events onsequence of) Due to (or as Examine requires that the death certificate be executed burial-transit oronari aftending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No by the detached Ö 9 Unknown 9 Unknown ₫. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an has autopsy certificate OPD. 1 ☐ Yes 1 □Yes 2 A No 25. Was case ref\_rred to medical examiner? 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No
27. Manner of Death Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1555 LOVIN 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Division or Attending 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009

State Registrar

AUG 2 4 2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Porter, 311 N. 4th St., Oakland, MD 32. Registrar's Signature

H0064705

21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 45 AM 2009 AULKER IESTINA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery and Kehab Sligo Creek If Under 24 Hrs. Mursing TAKOMA 9. Birthplace (State or Foreign 8. Date of Birth Dec. 9,1952 5. Social Security Number 065-80-2712 If Under 1 Year / Months Days 6. Sex 7. Age (In yrs. last birthday) Months Hours Min Sierra Leone 56 1XM 2□F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Silver Spring 1 Yes 2 No Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3740 Bel Pre Road, #5 20906 Sierra Leone Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 □ Never Married 2 □ Married Black 1 ☐ Yes 2 XNo Specify: Specify Completed by If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Licensed Practical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sankoh Konjo Matorma Moriba Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3740 Bel Pre Road, #5 Silver Spring, Maryland20906 Arnold S. Caulker -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 8/29/2009 Adelphi, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colorectal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Nnknown Hypertension; Diabetes 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2【 No 24a. Was an autopsy performed? Yes 2 XNo 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4X Nursing Home 5 ☐ Residence 1 ☐ Yes 2 XNo 0 6 ☐ Other (Specify, 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: after death.

**Funeral** 

Director

or items 23a or 28a-f show

or other traumatic avent, the Medical Examinar must be nutified at

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and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oths any injury or other traumatic ances.

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page 2 should be

Examiner

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D28656 August 14, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 15225 Chady Grove Road, #208

Rockville, Maryland 20850

State Registrar 31. Date filed (Month, Day, Year)

AUG 18



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 445AM Anthony Eugene Crowder 2009 74605T /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Lanham Doctors Community Hospital Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F 579-02-3190 36 01-23-1973 **Director** Washington, Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6320 Inwood St. 20785 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2X No ģ 3 ☐ Widowed 4 X Divorced Year or Dates: "natural" Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \, th \end{array}$ College (1-4or 5+) Security Office Bldg 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental George W. Stover III Joyce Crowder ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Crowder (Mother) 6320 Inwood St. Cheverly, Maryland 20785 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages Department of Important: If It any Injury or c 1 ☐ Burial 2 I Cremation 3 ☐ Removal from State Aug. 21, 2009 Beltsville, Md. Chesapeake Crematory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Mcensee 22. Name and Address of FacilityW.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington, DC 20010. 23a. P.H.1. Inter the Kease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, how, or heart callure. List only one cause on each line. Approximate Interval Between Onset and Death truedine Cause inal dis e or condition resulting in death) Hespiratury **Physician** /Medical Due to (or as a consequence of): Examiner Encepha Workthy 4100X1C if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine tra-stage physician and s the burial-tran-Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ 1 Yes 2 No 3 Probably 4 Unknown Completed C-ditt Colitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an med? 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1☐Inpatient 2☐ER/Outpatient 3☐DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8/13/09

State

Maryland 21215-0036

altimore,

Division of Vital Records, P.O. Box 68760,

Registrar

8118 Good

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alemu,

Fasil

AUG 1 9 2009

31. Date filed (Month, Day,

MO

32. Registrar's Signature

LUCK Road Lanham MD. 20706

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	otato of maryiar		Certificate of		•	Reg. No	, m, - , m,	27976
ı	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of De Month August		Yoo Year	3. Time of Death 11:00 P M
*	/Medic Examin		Anita 4a. Facility Name (If not institution, giv 5100 Hagan Road	Lois re street and number)	Cov	ert 4b. City, Town, o Temple Hi	r Location of Death	1	4c.	County of Death Prince Geo	
	Funeral Director		Social Security Number 6. 8	Sex 7. Age (In yrs	. last birthd	ay) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da January	th av, Year) 1, 19	9. Birth Cou Was	place (State or Foreign intry) shington, DC
	ס	ı	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or	Location					10d. Inside City Limits
	the Ma	ectc	Maryland   Prince Ge	orge's Te	mple Hi	10f. Zip Code			10a Cit	tizen of What Cou	1 □ Yes 2√√ No
	23a or	Funeral Director	5100 Hagan Road			20748			rog. On	USA	nuy:
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event har must be naithed at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 □ Yes 2 □ No If Yes, Give A Year or Dates:	J.S. 1	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>1 ☐ Yes 2 XNo</li> </ol>	ispanic Origin? (S an, Mexican, Puerti Specify:	pecify Ye's or No Pican, etc.)	)-	14. Race - Amer Black, White, Specify: Wh	
5-0	72 hc	etec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De	ecedent's Usual Occup live kind of work done e. DO NOT use retired	ation during most of wor	king	16b. K	ind of Business/Ir	idustry
121	within iene. than	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		inistrative A			Aut	tomotive I	ndustry
pc 5	e filed al Hyg other vent, I	Se C	17. Father's Name (First, Middle, Last	)	1		18. Mother's Nam	ne (First, Middle,			
ylar	Duld be Menta arked aric er	10	Henry	Weber			Gerti		Goody		
, Mar	and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship Karen Elliott / Daug	nter	510	ailing Address (Street O Hagan Road	Temple Hil		and	20748	
Baltimore, Maryland 21215-0036	Pages 1 tment of H tant: If Iter jury or oth		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Special Content of the Conte	y) Mai		sposition (Name of crematory or other place Vet. Cemeter	y 08/2	Date 0/2009		ocation - City or T eltenham, l	,
Bal	permit. Departr Imports any inju		21. Signatur Funeral Service Lice	nsee		22. Name and Addre	Ge	orge P. K on Hill,	alas Maryl	Funeral Holand 20	ome P.A. 745
	Physician /Medical		23a. Perf. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ILE D					81	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions	h.	quence on).						
	ted sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
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68760,	ficate I physi s the b	Medical		d							
P.O. Box (	The law requires that the death certi ate has been signed by the attending bage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			23d. Date of deliv	very Day Year
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/ita	ician: sertific setor, I	Be C	25. Was case referred to medical examiner?				26. Place of Dea			1 1 1 1 1 2 3	2 🗔 140
of	Physi r this c ral din	<u>۲.</u>	1 ☐ Yes 2 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpa		4 LI Nursing H			6 ☐ Other (Spec	ify)
0	nding f tth. : After e funera	ation	1 XX atural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	Injur	y Worl	yat (? Yes 2 ∐No	28d. Describe I	now injui	ry occurred	
Division of	tal or Attending Physician: s after death. al Director: After this certific ed in by the funeral director, i	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm,	street, factory, office		28f. Location (S City or Tox	Street ar wn, State	nd Number or Rui e)	ral Route Number,
	To the Hospital or, within 24 hours after To the Funeral Dire completely filled in the complete of the complet	Medical (	29a. Certifier (Check only one)  Certifying Pl	nysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, de ation and/o	eath occurred at the til r investigation, in my c	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s	s) and manner as d place, and due	stated. to the cause(s)
	Vithi Vort	ž	29b. Signature and Itila of certified			29c. Licens		29d. Date signed (Month, Day, Year)			
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	EX.	?	30. Name and address of person who	vski DO 9	200	BASIL G	Sty Ze	D LAK	90	NOZ	9774
	Sta Registra		31. Date filed (Month, Day, Year)  AUG 19 200	32 Registrar's Sign	A A	asked			1		/

DHMH 17 Rev 1/2001

			For State Registrar	State of	Maryland .	•	artment of F		•	giene Reg. No. 20	09	27977
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath		. Time of Death
	Physici /Medic		William C.	Carter					Augus		009	1955 ™
	Examin		4a. Facility Name (If not institution,	give street and numb	per)		4b. City, Town, o	r Location of Deat	th	4c. County of	Death	
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	Funeral Director		5. Social Security Number 248-44-3333	5. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last . <b>7</b> 5		Months Days	Hours Min.	. (Month, Da	ıy, Year)	Country)	e (State or Foreign
b			Usual Residence of Decedent		13				April	14,193	4 SC	<u>.                                    </u>
	yland		10a. State 10b. County		10c. City, T	own or Lo	cation					Inside City Limits
	e Ma	cto	MD P	PG	0	xon	Hill					1 X Yes 2 □ No
	ilt t	Dire	10e. Street and Number				10f. Zip Code	7.4.5		10g. Citizen of Wha	,	
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Evanier must be notified at	Funeral Director	5614 Fargo Av			140.1	207		0if>/N	Unite		
	ter de item	ᇤ	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ★ Marrie</li></ul>	12. Was Decede Armed Force 1 Types 2	es?	13. V	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	rto Rican, etc.)	Black,	American II White, etc.	noian,
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and	و م ج	Be	17. Father's Name (First, Middle, La Virgil Carte	,					ine (rirst, Middle,	Maiden Surname)		
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ď.	/Medical Examiner		resulting in death)	Due to (or	as a consequen	ce of):	-0.7				11	11 - 1
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j ,	the dr	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		. 3	dotner (specify) _					
Γ.	s mar ned b	by Pt	Part II. Other significant condition	s contributing to deaf	th but not resulfin	g in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ute to the ca	ause of death?
cords	quire en sig uld b	q pe	URINAYT	TRACT	Weel	Lor	/		1 🗆 ነ	Yes 2 □ No 3	☐ Probably	y 4 Unknown
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5	After After funer	ion	27. Manner of Death Natural 5 Pending		Day, Year) 28	b. Time of Injury	Worl		28d. Describe I	how injury occurred		
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<u> </u>	after s after i Dire	Certification: T	4 ☐ Homicide determin	ed building	, etc. (Specify)	, 141711, 4114	eet, factory, office		City or Tov	wn, State)	0, 710,70,710	ato rambol,
	no the nospital or attending Prystoan: The law requires that the death certification is the normal state of attending prystoans. To the Tuneral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Exponential Control one)	Physician: To the be xaminer: On the bas and manner	is of examination	dge, death and/or inv	n occurred at the til vestigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) and manr date and place, and	ner as state d due to the	ed. e cause(s)
1	within To the compl	Me	29b. Signature and title of certifier	ndees	n'		29c. Licens	e number	4	29d. Date signed (	Month, Day,	Year)
1	1+1		30. Name and address of person w	no completed cause	of death (Item 23	la) (Type, I	Print)	500:	7	110 20	73:	<u></u>
	Sta	te	31. Date filed (Month, Day, Year)	32. Rec	jistrar's Signature	1-	~ ~ 3	3 00 /	,0 ( 000 )0	00 20	, 2	
	Registr		AUG 1 9 2009	Beneval	gistrar's Signature	ake						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#4C+6 perFH, 8-24-09, BWI, Moco Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 123 **Physician** Month 5:40 P M 2009 Philip Ben Dwoskin /Medical 4a. Facility Name (If not institution, give street and number) At County of Death Anne Arundel 4b. City, Town, or Location of Death Examiner Atria Manresa Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Date of Birth (Month, Day, 1 M 2 M Days Hours Min 398-09-4708 91 **Director** 03/05/1918 Wisconsin Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f shov 28a-f shov 1√2 Yes 2 No Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 85 Manresa Drive 21409 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑ Yes 2 □ No If Yes, Give Year or Dates 1943—1946 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No ģ Specify. 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US Dept. of than College (1-4or 5+) Elementary/Secondary (0-12) Agricultural Economist Agriculture es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Dwoskin Dora Cohen 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mitchell Dwoskin / son 2637 Woodley Place, Falls Church, VA 22046 Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1
Department of I
Important; If ite
any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Judean Memorial Grdn: 08/16/2009 Olney, MD 22. Name and Address of Facilit Danzansky-Goldberg Memorial Chapel 21. Signature of Funeral Ser 1170 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Years disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ W 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No. 24a. Was an page 2 s has autopsy certificate 2 N 1 □Yes 2 410 Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☐ 🕍 🗸 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only within 2. and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

AUG 18

DHMH 17 Rev 1/2001

who completed cause of Jeath (Item 23a) (Type, Print)

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** James Robert Dalton 3:15 A<sup>M</sup> 9 2009 /Medical August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 ▼ M 2 □ F 84 02/21/1925 Director 121-16-6750 NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If them 27 Is marked other than "natural", or thems 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic event, the Medical Examment or other traumatic events or other events or ot 1 ☐ Yes 2 🙀 No Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Meadow St 21811 #113 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married DALTON, JAMES Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electric Company contractor rep 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Dalton Lillian Gilbond ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John Starr</u> step son 418 Stone Schoolhouse Dr Bloomingburg NY 12721 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Cape Hen Topen Crem 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/11/2009 Frankford DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service 108 William St Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) PULMONARY CHRONIC OBSTRUCTIVE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No Division of Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 2 12 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and Ittle of certifie 29c. License number

DHMH 17 Rev 1/2001

State Registrar

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EDSTERN SHARP DR. SALISBURY MDZ/804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1HMMARAYA

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

Dora Mae Defiba	_	Sta - For State	ate of Maryla		artment of		and	Menta	al Hyg		g. No.	20	0 2708
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)						2.	Date of Deat	n	V	3. Time of Death
Medical Examin		Dora Mae Defi	baugh							Month August 13	2009	Year	1600 hrs
		4a. Facility Name (if not institution	n, give street and nur	mber)	4	b. City, To			Death			nty of Death	
	н	Malcolm Grow Hospita	al			Camp	Spring					e George	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.			Co	thplace (State or Foreign puntry)
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Division of Vital Records, P.O. Box 6876 within 24 hours after death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Ë	27. Manner of Death	28a. Date (Mont	e of Injury h, Day Year) , 2009	28b. Time of	Injury 2		y at Work	. [	28d. Describe Oriver auto			
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12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
(		30. Name and addre		/ 4							_	MD 208			

DHMH 17 Rev 1/2001

/Medi Exami

1 - For State Registrar

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Expringer must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Nam	e (First, Middle, La			•				Date of Dea     Month	ath Day	Year	3. Time of Deat		
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ner	4a. Facility Name (	f not institution, gi	ive street and number)			4b. City, Towr	, or Location	of Death		4c. 6	Sounty of Deal	th		
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Г	5. Social Security N	lumber 6.	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Ye	ar   If Unde	r 24 Hrs. Min.	8. Date of Bird (Month, Da March		9. Birt	thplace (State or For	reign	
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	Usual Residence of											-		
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2	Maurice	E. Eckeni	rode				Abb	oie E	lizabet	h B <b>r</b> ı	ınner			
-	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Rura	al Route Numb	er, City or	Town, State,	Zip Code)		
	Lawrence	F. Selby	y/Friend	!	527 0	Good Hop	e Rd.	Frie	endsvil	le, N	4D 215	31		
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			Removal from State			natory or other		. 3	21 20	<b>^</b>	````			
		5 Other (Special		Coun								ville, PA		
	21. Signature of Fu	ineral Service Lice	ensee X)	ma.	\ I				wman Fu			-		
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	23a. Part 1. Enter t shock, or hea	he discase, or con art famure. List only	mplications that caused y one cause on each lir	I the death. I ne.	Do not ent	er the mode of	dying, such a	s cardiac o	or respiratory a	rrest,		Approximate Interval Between		
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<u>F</u>	Part II. Other signi	ficant conditions	contributing to death be	ut not resultin	ng in the u	nderlying cause	given in Part	1.	23e. Did t	obacco us	se contribute to	o the cause of death	1?	
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atio	1 ☑ Natural 2 ☐ Accident	5 ☐ Pending investigation		y, rear)	gur y		Vork: ☐Yes 2[	□No						
ij	3 ☐ Suicide	6 ☐ Could not to determined	a 28e. Place of inju	ury - At home	, farm, str	eet, factory, offic	е				i Number or R	ural Route Number,		
Certification: To	4 ☐ Homicide		building, et	с. (эреспу)					City or To	vn, State)				
	29a. Certifier		Physician: To the best											
edical	(Check only one)		aminer: On the basis o and manner sta	f examination										
ĭ	29b. Signature and	title of certifier				29c. Lic	ense number			29d. Date	signed (Mon	th, Day, Year)		
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е	31. Date filed (Mon	MC 24	2009 32. Redistr	ar's Signature		1.41								
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Registrar

Division of Vital Records, P.O. Box 68760, 4 hours after death.

\*\*uneral Director: Pely filled in by the fu

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WB, Greenoughtho



29c. License number

DO4383

5505 Hoplins

29d. Date signed (Month, Day, Year)

Angust 11, 2009

Boy view civele

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death **Physician** AUGUST 12009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Months Days 03/07/1913 1**X** M 2□ F Hours 492-22-1708 96 MO Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3330 North Leisure World Blvd, Apt 314 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 21 No Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Operator Retail Stores-Shoes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Fischer Jennie Rosenthal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Fischer-Wife 3330 North Leisure World Blvd, #314 Silver Spring,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2 ☐ Cremation 3 X Removal from State Beth Hamedrosh Hagodol 8/17/2009 5 Other (Specify) Ladue, MO 4 Donation 21. Signature of Joneral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 MO1255 23a. Parfi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnar-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and Atte of certifier, 29d. Date signed (Month, Day, Year) AU6UST 15, 2009 MONTROSERD, ROCKVILLE MD ZOSSZ

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200° **Physician** 12:55 PM Julia Ann Gagne AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner CIVISTA MEDICAL CENTER LATT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | October 30, 1937 Birthplace (State or Foreign Country)
 MA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 224-48-3591 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notifiled at 1√ Yes 2 □ No Director MD Charles La Plata 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 123 Huckleberry Drive 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ∐Yes 2 TNo If Yes, Give X Year or Dates: 1 □ Yes 2 No Specify: Specify: White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent School Board 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph McCormick Dorothy\_Dyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey Gagne/Husband 123 Huckleberry Drive, La Plata, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/16/09 Brinsfield-Echols Crem. Charlotte Hall,MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01458 AREHART-ECHOLS FUNERAL HOME, P.A. 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying, such as carriac or respiratory arrest, smoother to the mole of dying are the mole of dyi Approximate Interval Between Onset and Death Anteroseptal myocardial infarction Immediate Cause (Final **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Hypertension sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by a Diabetes mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 4No 1 ☐ Yes 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 **1**0 Medical Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 £ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sindword 20061614 August 14th, 2009.

Registrar DHMH 17 Rev 1/2001 RAVINDER

death with the Maryland

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land

Baltimore,

Pages 1 and 2 should Mary

Physician: The law requires that the death certificate be executed

or Attending

Division of Vital Records, P.O. Box 68760,

300

6 POSTOFFICE RD, SUITE 101, WALDORF, MD 20602

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Senewa

SINDHWANI, M.P.

			For State Registrar	State of Mary	•	rtificate of		Reg. N		27006
	Physici /Medic		1. Decedent's Name (First, Middle, La MARION SEA					2. Date of Death Month D	ay Year	3. Time of Death 2:35 M
	Examir	ner	4a. Facility Name (If not institution, give North Aconocil H	e street and number) EALTH & RE	400	4b. City, Town, of GIEN BY	r Location of Death		c. County of Death AnいらA	
	Funeral Director		5. Social Security Number 6. S 216-24-6506		yrs. last birthday) Yrs.			8. Date of Birth (Month, Day, Year (0-2-2		nplace (State or Foreign intry)
	/land		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary Ba-f sh Iified	ctor	MD. ANNEA	RUNDEL	GLEN		£			1 □Yes 2 No
	ath with th	Funeral Director	301 Hospital D				061		itizen of What Cou	4.
920	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show amy highty or other traumatic event, the Medical Examinat must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 I	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
215-0036	"natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	16b.	Kind of Business/I	
212	d within giene. er than "	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	Hou	HEMAK		a	un H	OME
Maryland	uld be filed Aental Hygi rked other tic event, II	To Be (	17. Father's Name (First, Middle, Last	ONK			18. Mother's Name	(First, Middle, Maide	n Surname) 🔾	JK
<i>l</i> lary	2 shound In and In is ma		19a. Informant's Name/Relationship (		10-1		Λ	l Route Number, City		
	s 1 and f Health item 27 other t	1	JEAN HUTCHINSON, N 20a. Method of Disposition		Db. Place of Dispo	EATNER/E psition (Name of matory or other pla		ate 20c.	Location - City or T	
Baltimore,	Page: ment o ant: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Hemovai from State		IN CEMET	i	6-09 W	WHAW	N. MD.
Balt	permit, Departr Importa any inju		21. Signatur of Europal Service Licer		2	2. Name and Addre	ess of Facility DA	//	DONAW WERAI H	
	Physician	in 1	23a. Part I. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one oause on each line.	death. Do not en		ng, such as cardiac d	r respiratory arrest,	, MD. Z	Approximate Interval Between Onset and Death
-	/Medical Examiner		resulting in death)	a. ue to (or as a cor	nsequence of):	umenta				
	T +	ner	Sequentially list conditions, any localing Lamb delications cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to or as a cor	nsequence of):					
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68760,	rtificate be executed ng physician and as the burial-transit	Medical E	· ·	d						
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of deli Month	very Day Year
S, P.	es that igned b		Part II. Other significant conditions	contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacco		the cause of death?
Records,	w requires t s been signe should be	eted	Fulure to thry	4, Demin	ha			3	7	obably 4 Unknown
al Rec	n: The law icate has l r, page 2 s	Completed by						24a. Was an autopsy performed?	prior to d	topsy findings available completion of cause of
f Vital	ystciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Oth	26. Place of Death ner: 4 Nursing Hor	(Check only one) me 5 ☐ Residence	6 ☐ Other (Spec	cify)
ou of	ing Ph After th uneral	ion: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time o Injury	Woi	ry at 2	28d. Describe how inj		
Division	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		At home, farm, str pecify)		]Yes 2□No	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
	he Hospitz in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Pi	nysician: To the best of my miner: On the basis of exa and manner stated.	/ knowledge, deat mination and/or in	th occurred at the to	ime, date and place, opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	To the Community of the	Ž	29b. Signature and title of certifier	MA		29c. Licens	se number	29d. C	ate signed (Month	n, Day, Year)
	2		30. Name and address of person who	011		Print) Mcch	1000 Su	Of a V	Burnio	MD 21061
	Sta Registr		31. Date lifed (Month, Day, Year) SEP 0 1-20	33 Registrar's S	OS CYU.	aka		1	,	

DHMH 17 Rev 1/2001

09-06266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lamour Blake 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 10, 2009 2211 hrs Medical Examiner Lamour Angela Blake Harrison c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Min Director M 2 **X** F Yrs 12/12/1971 Jamaica 214-51-5079 37 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No or 28a-f shov Silver Spring Maryland Montgomery with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code notified at 20906 U.S.A. 3654 Bel Pre Road, #22 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or item or other traumatic event, the Medical Examiner must by Armed Forces? White, etc. 2 X Married 1 Never Married Yes 2 X No **Rlack** Yes, Give Year 2 X No specify Specify. Divorced 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Nurse Tech Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Williams Redley Blake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 13955 Valleyfield Drive, Silver Spring, Maryland 20906 Alfred Winston Blake - Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tant: 08/21/2009 Silver Spring, Maryland Gate of Heaven Cemetery Other Specify. Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M01294 Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a Multiple Sharp Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED the attending physician and for use as the burial UNPENDED O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown g Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions ģ Yes 2 ✔ No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an need prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 V Yes No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA Residence 6 this 1 V Yes No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Aug 10, 2009 Subject stabbed 2129 hrs Natural Yes 2 V No Director: within 24 hours after death.

To the Funeral Director: Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 3654 Bel Pre Road, Silver Spring, MD determined 4 V Homicide (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. Lo 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12 August 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 31. Date filed (Mr Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

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			For State of Mar State Registra MEND#12perFH, 8-24-09, BWW, Mo	yıand / Depa Co <i>Cer</i>	artment of H rtificate of L			ene g. Nó. 009	27988
	Dhariai		1. Decedent's Name (First, Middle, Last)	<u> </u>			2. Date of Death		3. Time of Death
	Physicia /Medic		Clement Townsend Hertslet				August		2:45 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  National Lutheran Home		4b. City, Town, or Rockvi			4c. County of Deat	
	Funeral Director			in yrs. last birthday). 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 25		thplace (State or Foreign
	w w		Usual Residence of Decedent  10a. State 10b. County 1	Oc. City, Town or Loc	cation				10d. Inside City Limits
	Maryla -f sho	tor	· · · · · · · · · · · · · · · · · · ·	Boyds					1 ☐ Yes 2 🔀 No
	or 28a	Director	10e. Street and Number	20,40	10f. Zip Code		10	g. Citizen of What Co	puntry?
	th wit		14408 Saturn Way		20841		U1	nited Stat	es
36	be filed within 72 hours after death with the Maryland Ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Modical Exercitive must be muffled at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His fYes, specify Cubar I □Yes 2 🙀 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
2-0-	2 hou natura ical E	ted	15. Decedent's Education (Specify only highest grade completed)	16a Deced	dent's Usual Occupa	ation	1	6b. Kind of Business/	Industry
121	rithin 7 ne. <b>han "r</b>	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1	kind of work done d OO NOT use retired;			Departmen	
2	filed w Hygie ther t		17. Father's Name (First, Middle, Last)	Senio	r Researc	18. Mother's Name		Defense aiden Surname)	!
<u>a</u>	e de be	To Be	Clement Townsend Hertslet			Marie Dau	•	,	
Maryland 21215-0036	s 1 and 2 should be f Health and Menta ftem 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type. Print) Mary F. Hertslet (Spouse)		ng Address <i>(Street a</i> <b>Saturn</b> W			City or Town, State, 2and 20841	Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any njury or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos of Place of Dispos Of Place of Dispos Of Dispos Cemete	natory or other place	Augus	st 17,	Oc. Location - City or	
Balt	permit. Departi Importi any nj		ature of Fugeral Service Lights 46066		Name and Addres  O E. Deer			ral Home thersburg,	MD 20877
1	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due (or as a condition or shock)	1 Sto	$\wedge$	g, such as cardiac o	^		Approximate Interval Between Onset and Death
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68760,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last C. Due to (or as a c	onsequence of):					
	± 5, a		IF FEMALE:					1	
O. Box	requires that the death certific been signed by the attending p hould be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
rds, P.	quires that en signed b uld be deta		Part II. Other significant conditions contributing to death but r	not resulting in the un	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to s 2 □ No 3 □ P	o the cause of death?
II Kecords,	The law ate has b	Completed by	,				24a. Was an autopsy perform 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of
/Ital	Ician: sertific ector,	Be (	25. Was case referred to medical examiner?		0.11	26. Place of Death	(Check only one	)	
0	Phys	<u>ٿ</u>	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient  27. Manner Ceath 28a. Date of Injury	2 ER/Outpatien		4 Marsing Ho	me 5 Resider	nce 6 Other (Spe	ecify)
0	nding tth. : Afte e fune	tion	1	(ear) Injury	Work	? /es 2 □No	Edd. Describe not	winjury occurred	
DIVISION	al or Atter s after dea nl Director ed in by the	Certification:	S C Could not be	- At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of real decirition of the basis of evaluation and manner states.	kamination and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ca	tuse(s) and manner a te and place, and due	s stated. e to the cause(s)
	Vithi To th	ž	29b. Signature and title of certifier	1.	29c. License	number	29	d. Date signed (Mont	th, Day, Year)
	611		Charles W. / O	reshr	) UA	100	H	1905/13	,2009
			30. Name and address of person who completed cause of deal Charles W. Keresh, M.D. 2603	th (Item 23a) (Type, I 33 Ridge F	*	ascus MD	20872	7	
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's	Signature		Jocus, FID	20072		
	Registr	ar	AUG 18 2009 Sentia	A. par					

09-06	682	
Linda	Jane	Hopkins

da Jane Hopk		- For State	State of	Maryland / D		ment of H icate of D		d Ment	aı Hygier	1 <b>C</b> Reg.	No	20	09 279
Physicia	F	Registrar	ne (First, Middle,Last)						Mor	e of Death	)av	Year	3. Time of Death
edical Exami	ner	LINDA JA	ANE HOPKINS	X					Aug	just 26, 2	2009	nty of Death	1537 hrs
		4a. Facility Name	(if not institution, give s	treet and number)			City, Town, or Baltimore	Location of	f Death		4c. Coul	ny or Death	
		University  5. Social Security		7. Age (In	yrs. last		If Under 1 Year	r If Under	r 24Hrs. 8. D	ate of Birth	(MM/DD/Y		thplace (State or
Funeral Director	- 1	215–58–7.		2 <b>X</b> F 58		_	Months Days	s Hours		/24/1	951_	Foreig Co	untry) <b>KY</b>
ě	F	Usual Residence 10a. State	of Decedent 10b. County	100	c. City, To	wn or Location							10d. Inside City Limits
l Iow any		MD	TALBOT	١,	EASTO	M							1 Yes 2 X No
Maryland 28a-f show	용	10e. Street and N			LILLO I C		10f. Zip Code			10g	. Citizen o	f What Cou	ntry?
th the Maryland 23a or 28a-f sho	Ë	10 NORT	H HANSON ST	TREET APT.	В		21601				ISA		
death with the Maryland or items 23a or 28a-f shunust be notified at once	era	11. Marital Status		12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was I If Yes	Decedent of His , specify Cubar	spanic Orig n, Mexican,	gin? ( Specify <b>`</b> , Puerto Rican	Yes or No- , etc.)		Race - Amer Vhite, etc.	ican Indian, Black,
r death	Funeral Director		rried 2 Married  4 X Divorced	1 Yes 2 X	No		es 2 <b>X</b> No	specify:			Spec	cify: WH]	TTE
rs afte ural", miner	à	3 Widowed	Education (Specify only	or Dates:	eted) 10	6a. Decedent's	Usual Occupa	tion (Give	kind of work de	one		of Business/	
72 hours "natur	Completed		condary (0-12)	College (1-4 or 5+)		during mos	t of working life	e. DO NO I	use retired)	ŀ			
5-0036 Tled within 77 Hygiene. d other than	du	10				HOMEMA	KER	40.14-11	r's Name (First	Middle M	OWN I		
15-0 filed w Hygic d othe			e (First, Middle, Last) <b>E SAYLOR</b>						LE RAE			iumo)	
2121 vuld be fi Mental I marked	To Be		Name/Relationship (Type	oe, Print )		19b. Mailing	Address (Stre					Town, Stat	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after perperment of Health and Mental Hygiera. Important: If item 27 is marked other than "natural", of injury or other traumatic event, the Medical Examiner:	-		E RAE CHERI		ER	4272 W	INDRUSE	ROAL			21	654	
e, h l and Healtl item		20a. Method of D	Disposition	Removal from State	20b. Pla	ace of Dispositi ematory or othe		emetery,	Date	е	20c. Loca	ition - City o	r Town, State
Baltimore, permit. Pages I au Department of He Important: If ite		1 X Burial 2	5 Other Specify:	Removal nom State	WHI?	TEMARSH			8/31/2				ARYLAND
ialti rmit. spartm nports jury o			Funeral Service Licens	ee		FEL	me and Addres	ss of Facilit	BEIN &	NEWNA	M FU	NERAL	HOME, P.A.
		Sold Foto	r the disease, or compli	cations that caused the	e death. D	200	SOUTH mode of dying	HARR g, such as o	LSON S3 cardiac or resp	iratory arre	st, shock,	or heart	Approximate Interval
Physician Medical	-	failure. List	only one cause on each	h line.									Between Onset and Death
caminer		Immediate Caus or condition resu	ulting in death)	Intracerel oue to (or as a consequ	uence of):								
		Sequentially list	conditions.	Atrial fib			ind con	gesti	ve hear	rtfai	lure		
	iner	if any, leading to cause. Enter Ur											
- ii	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause												
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dri sici	ledical			23c. If yes, outcome	e of pregna	ancy					23d. D	ate of delive	
6876 certificate ading phy se as the b	Physician/M	23b. Was deceded	ent pregnant in the https://doi.org/	1 Live birth		<sub>2</sub> Fet	u	B Ectop	oic pregnancy		Mo	onth	Day Year
Box 6 e death ce the attend ed for use	sici	1 Yes 2	No 9 🗸 Unknown	4 Pregnant at til	me or dea	oth 5 Oth	ner (Specify)						
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the?	Phy		gnificant conditions	contributing to death I	but not res	sulting in the u	nderlying cause	e given in F	Part I.				to the cause of death?
P.O.	Completed by	Mult	iple injur:	Les; chron	ic al	lcoholi	sm:		N	Č.			robably 4 V Unknown
ords, w requir s been s should	ete	chemi	cal anticoa	agulation	_					24a. Was autor	osy	24b. were prior t death	autopsy findings available to completion of cause of
eco he law ate has	ह	<u> </u>								1 ✓ Yes	rmed? 2 No	1	
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Vita hystoi this c	10	1 🗸 Yes	2 110	lospital: 1 Inpatien		ER/Outpatient 28b. Time of I		njury at Wo	Nursing H	ome 5	Residence how injury		her:
n of \ding Ph After tl		27. Manner of D		28a. Date of Injury (Month, Day,Ye	ar)		1	Yes 2					iple falls
Sior Attend r death ector: by the	Fellow Fig. 1 Accident Investigation Fd 8/24/09 Fd 5:50 pm								etc. 28f	f. Location (	Street and	Number or	Rural Route Number, City
Division of Vital Records, tat or Attending Physician: The law requirers after death.  To after death.  To a Divector: After this certificate has been sized in by the funeral director, page 2 should be	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify) house									or Town, s aston	, MD	N . H	anson St
Hospi 4 hou Funer elv fil	<u>a</u>	29a. Certifier (Check only	Contifuing Physici	an: To the best of my	knowledg	ge, death occur	ccurred at the time, date and place, and due to the cause(s) and mai tigation, in my opinion, death occurred at the time, date and place, a					manner as s	stated.
To the Hos within 24 h To the Fur	Medical	one) 2		On the basis of examand manner stated.	nination ar	nd/or investigat				e time, date			(Month, Day, Year)
Fara	ž	29b. Signature	and title of certifier					ense numb C.M.E.	er		1	st 27, 20	
		alle	18		- 1 A	220)		V. VI.∟.			1.59		
		30. Name and a	address of person who	completed cause of de nt Medical Exam		23a) 111 Penn S	Street, Balti	more, M	ID 21201				
	State		Month, Day, Year)	32. Registrar	's Signatu	ıre							
Regi				Denney	8. A	parke	,						
DHMH 17 Rev 1	/2001			r	100	ORIGINA	<b>NL</b>					OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay. 2009 Patricia Ha11 August 8:08A M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 51 yrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 579-80-0335 221958 NC March Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County Washington DC Ves 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20032 4th Chesapeake St. SW Apt. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No Specify. Specify: Black \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PG Schools Teachers Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Donald Hall Ruby Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Hall/ Mother 23rd Parkway Temple Hills MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bladensburg MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln 08 - 22 - 200921. Signature of Funeral Service Licens 22. Name and Address of Facility 20019 Dunn&Sons 5635 Eads St Washington DC (a) 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRHYTHMIA FATAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 □ DOA မ 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Box 68760, P.0. detached ģ signed ! Records, page 2 should peen has certificate Division of Vital Hospital or Attending Physician: 24 hours after death. director, this funeral After the Funeral Director: Af

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the fredict Eventre, must be notified at

72 hours after

1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than

permit. Pages 1 and 2 s. Department of Health ar Important: If Item 27 Is any Injury or other traus

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

To he I within 2 To the

ANDESCAVAGE State

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HOSPITAL

29d. Date signed (Month, Day, Year)

8/14/69

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 2009 Stirling Gordon Huntley August 12:57 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours 578-22-0007 Washington, D.C. 86 Jan 1, 1923 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10011 Menlo Avenue 20910 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 1943-45 Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only nighest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Courier Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Huntley Maud Ink 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Huntley/wife 90 Waverley Drive W-103 Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Final Journey Crematory 08/17/09 Woodbine, MD 5 Other (Specify) 4 Donation Name and Address of Facility tion Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence or): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 □ 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

show

28a-f

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23a death

, or items

"natural"

72 hours after

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 is marked other i any Injury or other traumatic event. In

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

Be

MD

traumatic event, the Middeal Evan Incl. rust be notified at

/Medical

and burial-trai signed by the attending physician I be detached for use as the buria s certificate has the irector, page 2 s Hospital or Attending Physician:

The law requires that the death certificate be executed

P.O. Box 68760

of Vital Records,

Division

Physician/Medical \$ Completed Be ij Medical Certification: To this

Examiner

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?
1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0055918

29d. Date signed (Month, Day, Year)

2009

M,D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K055 SWITLES MD 76.00 CARPOIL AVE TAKEMA PK, MB 20912

1 9 31. Date filed (Month)

29b. Signature and the of certifier

Pegistrar's Signature

		For State Registrar	State	of Maryla	•	artment o			Mental Hy	giene Reg. No.	200	27992
Physicia /Medic		1. Decedent's Name (First, Middle, Freda Henry	Last)						2. Date of Dea Month 8/	ath 24/2	009 Year	3. Time of Death 520pm M
Examin		4a. Facility Name (If not institution, 7602 Garrison C	T.	ımber)		S	ever		1	4c.	County of Deat	h
Funeral Director		5. Social Security Number 400-84-2401 Usual Residence of Decedent	6. Sex 1 □ M 2 <b>√</b> □xF		s. last birthday			Under 24 Hrs. lours Min.	8. Date of Birt (Month, Da 3/11/	h y, Year) 1948	9. Birt Co	hplace (State or Foreign untry) LA
Maryland I-f show	tor	10a. State 10b. County	Arundel	10c. C	City, Town or L	ocation Severn						10d. Inside City Limits 1 ☐ Yes 3√√No
h with the	Funeral Director	10e. Street and Number 7602 Garrison C	т.			10f. Zip Co		21144		10g. Citiz	en of What Co USA	untry?
aryiand 21215-UU36 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, it a Madical Examinar man be rectified.	þ	11. Marital Status  X∑Never Married 2  Marrie 3  Widowed 4 Divorced	Armed F	<b>≱</b> XNo ive	U.S. 13.	Was Deceden If Yes, specify 1 ☐ Yes XX	Cuban, N	nic Origin? (S lexican, Puert pecify:	pecify Yes or No- o Rican, etc.)		4. Race - Ame Black, White Specify: W	
Z1Z15-UU36 d within 72 hours aff giene. er than "natural", or it Medical Exami	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed,	1-4or 5+)	(Give	edent's Usual C e kind of work o DO NOT use r sabled	one durin	n ng most of wor	king	16b. Kir	nd of Business/ None	Industry
laryland 212 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ite M.	To Be (	17. Father's Name (First, Middle, L Fred Henry	ast)				18.		ne <i>(First, Middle,</i> March He		Surname)	
tra Tra		19a. Informant's Name/Relationsh  Janet L. Barrow		Tool	760	2 Garri	son		vern, MD	211	44	
timo t. Page: rtment o rtant: If i		20a. Method of Disposition  1X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp	ecify)		th Har		Gar	1	/5/2009	Radc	-	Υ
Depariment of the control of the con		21. Signature of Funeral Service L			1	2 Ridge	ly A	ve. A	rdesty F nnapolis	, MD		
Physician /Medical		23a. Part 1. Enter the disease, or of shook, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	Pheu	meng	ter the mode o	f dying, si	uch as cardiad	or respiratory a	rest,		Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	(or as a conse								,
ob / ou, ificate be executed g physician and is the burial-transit	dical	resulting in death) Last	Due to	(or as a conse	equence of):							
The corras, F.O. BOX 06/00,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	itcome of pregr birth 2  Fe gnant at time of nown	tal death 3	□ Ectopic preg □ Other <i>(speci</i>				2	3d. Date of del Month	ivery Day Year
weduires that seen signed be should be deta	by P	Part II. Other significant condition	ns contributing to c	leath but not re	esulting in the u	inderlying caus	e given in	Part I.	23e. Did to		, _	the cause of death?
tending Physician: The law re leath.  ior: After this certificate has bee the funeral director, page 2 sho	Completed	OF Was an artist of the little							1 □ Yes	rmed? 2 AN	24b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of
Physician: r this certific	: To Be	25. Was case referred to medical examiner?  1 Yes 2 Death	Hospital: 1  28a. Date	Inpatient 2	ER/Outpatie		Other: 2		ome 5 Describe	ence 6		cify)
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o the Hos ithin 24 h o the Fur	Medical	(Check only 2 ☐ Medical E	xaminer: On the I	pasis of examination	nation and/or i	nvestigation, in	my opinio	on, death occu	rred at the time,	date and	place, and due	to the cause(s)
F 3 F 8		▶ Elliot	- Nu	JM			D	2009	Y	08	/25/	09
		30. Name and address of person was a street of the street	For bury	se of death (Ite	em 23a) (Type,	Made Sach	an f	Onk a	reve ble	en!	erne,	पर्व, 2100
Stat Registra	9	SEP (		Census	1	back	0					

DHMH 17 Rev 1/2001

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13, Month AUGUST 20.09 Physician 7:15A EVELYN **JANE** TMLER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/1/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2 □ TF 90 Director <u>206 01 3566</u> PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** Jefferson Frederick Co. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 2198 Bellemonte Ct 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No □Yes 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. þ Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Rose Daugherty Bowman ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2198 Bellemonte Ct., Jefferson, MD 21755 Paugh Patricia Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ţ, Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 8/17/2009 |Meyersdale, PA 15552 <sup>22</sup> Name and Address of Facility
William Rowe Price Funeral Home Inc.
325 Main St., Meyersdale, PA 15552 21. Signature of Funeral Service Lice CC0376 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 Tyes 2 Tho 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2 No 1 □ Yes 2 DA Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRINA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 18 Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Day Month Year **Physician** 22:31 M Willie Lee Jones 2009 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 **№**M 2 🗆 F Yrs. Director 267-42-4595 Nov 15,1931 FL Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show traumatic event, the Medical Examiner must be notified at 1 □Xes 2 □ No Funeral Director Wicomico MD Salisbury or 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 200 Civic Avenue 21801 USA items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 132Yes 2 □ No If Yes, Give Year or Dates: Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Black 'natural", or 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) n/a Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Eddie Tarvar Pearl Jenkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorenzo Britt/son 1305 Bennett Road, Orlando, FL 32814 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important; If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Eatonville, FL Eatonville Cemetery 8/22/2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home, avara 1618 West Road, Salisbury, MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □No 2 💢 No 1 TYes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title

30. Name and addres

JAFAR

31. Date filed (Month, Dat, Year)

of certifier

AUG 18

DHMH 17 Rev 1/2001

ORIGINAL.

CARROLL

person who completed cause of death (Item 23a) (Type, Print)

32. Reg

100 €.

1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ST

29c. License number

D68552

29d. Date signed (Month, Day, Year)

SAlisbury Md 21801

	,	For State Registrar		Marylan	id / Depa	artment of rtificate o	Health f Death	and M		giene 🤰 🏻 Reg. No.	199	27995
Physici	an	1. Decedent's Name (First, Middle Marjory Keene:							2. Date of Dea Month August		Year 009	3. Time of Death 6:35 A M
/Medic		4a. Facility Name (If not institution		nber)		4b. City, Town	, or Location	n of Death	August	4c. County		0.33 A ···
LAUIIII		Holy Cross Hos	pital				ver Sp	_			ntgo	mery
Funeral Director		5. Social Security Number 168–48–8275	. 🗆 💝	7. Age (In yrs. I 98	last birthday) Yrs.	If Under 1 Year Months Day		er 24 Hrs. Min.	8. Date of Birt (Month, Day Nov. 25	h Y, Year) <b>1910</b>	9. Birth Coul Oh	place (State or Foreign ntry) 10
land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
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/ith the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?
eath v	Funeral	3620 Littled		#115 dent Ever in U.	S. 13.3	Was Decedent of	20895		ecify Yes or No-	USA 14 Bac	e - Ameri	can Indian,
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Eventher must be nottled at	þ	1 ☐ Never Married 2 ☐ Marr  **XXWidowed 4 ☐ Divorced	Armed For	ces? 2 <b>X⊡X</b> No e		fYes, specify C 1 □Yes <b>X</b> XIN	uban, Mexic	an, Puerto	Rican, etc.)		ck, White,	
5-0	eted	15. Decedent	t's Education		16a. Dece	dent's Usual Oc	cupation	ost of worki	na I	16b. Kind of B	usiness/In	dustry
21215-0036 d within 72 hours aft gjene. than "natural", or the than "natural" or the "natural" or the than "natural" or the "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "natural" or "na	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of work doi OO NOT use ret			9	77 -	- 7 - 1-	<b>G</b>
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rian Jid be Vental riked of	TO B	Albert Keener					L	ena S	tussy			
Mary ind 2 shoralth and 1 strauma	- Market	19a. Informant's Name/Relationsl Quay K. Jones/S			19b. Mailir					er, City or Town,		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middle Eventhal Injury to notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🍱 Cremation 4 ☐ Donation 5 ☐ Other (S)				sition (Name of natory or other p Ltan Cre		Διια		20c. Location	-	own, State  Virginia
Balti permit. Departn Importa any Inju		21. Signature of Funeral Service	Licensee Moo	837	F1	Ameig Ad	ress c 52 ersity	Tins Blvd	Funeral	Home I	nc.	g, MD 20901
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68760, difficate be executed physician and is the burial-transit	al Exa	that initiated events resulting in death) Last	c. <u>Sleep</u> Due to (d	or as a consequ	uence of):							
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vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No		irth 2 🗌 Fetal ant at time of d	Ideath 3	Ectopic pregna Other (specify)					te of deliv	ery Day Year
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To the Hospital Within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 <sup>™</sup> Certifyin (Check only one) 2 Medical	g Physician: To the I Examiner: On the ba and mann	asis of examina	wledge, deatl	n occurred at the vestigation, in m	e time, date ly opinion, d	and place, eath occurr	and due to the red at the time,	cause(s) and m date and place,	anner as : and due t	stated. o the cause(s)
	Me	29b. Signature and title of certifier	1 00			29c. Lice	ense number			29d. Date signe		
9		30. Name and address of person					D41		Cnris -		•	2009
		Bergit Schoell 31. Date filed (Month, Day, Year)		1500 Fo		teu koa	a, S1	rver	spring,	MD 209	TO	
Sta Registr		AUG 18 2		A J A	Sans	10						

		1 - State Registrar	,	Cei	tificate of	Death	1	Reg. No.	UUS	2/99
Physicia		Decedent's Name (First, Middle, Last)     Leslie J. Kinney					2. Date of Dea Month August		200 <sup>Year</sup>	3. Time of Death 10:24A. M
/Medic Examin		4a. Facility Name (If not institution, give street a Laurel Regional Hospi			4b. City, Town, o Laurel	r Location of Death		4c. Cou	inty of Death	eorge's
Funeral Director		5. Social Security Number 6. Sex 1 M 2 [	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt Jan • 19	, <b>19</b> 25		place (State or Foreign Ity) III gan
Maryland a-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Georg		r, Town or Lo ver Spi					1	10d. Inside City Limits 1 □ Yes 2 No
with the 3a or 28s	Funeral Director	10e. Street and Number 3160 Gracefield Road,	#1223		10f. Zip Code 20904				of What Cour	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 7	s Decedent Ever in U. ged Forces? Yes 2∐No es, Give WW∐ ar or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 21 No	lispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecify: W	
in 72 ho n "natur fedical E	Completed	15. Decedent's Education (Specify only highest grade comp		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Kind o	of Business/In	dustry
iled with Hygiene. Iher thar Int, the N	Com	Elementary/Secondary (0-12) Col 12  17. Father's Name ( <i>First, Middle, Last</i> )	lege (1-4or 5+)	Owner		18. Mother's Nam	ne (First, Middle,			et Metal C
ould be f Mental I arked of atic eve	To Be	Charles Kinney		<b>,</b>		Flossie	Fairchi	.ld		
and 2 sh ealth and n 27 is m		19a, Informant's Name/Relationship (Type. Prin Mary Cannon -daughter	nt)			and Number or Rull Mill Ro				y <b>l</b> and 21029
Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Remova	I from State Gat	lace of Dispo emetery, crei	sition (Name of natory or other pla Heaven Ce	ce) Pmeterv 8	Date /14/2009		on - City or To	own, State ng , Maryland
permit. P. Departme Important any injury once.		4 □ Donation 5 □ Other (Specity)  21. Signature of Poneral Service Licensee				; -	I		-	yland 2070.
certificate be executed /Medical Examiner unding physician and ise as the burial-transit	Medical Examiner	Sequentially list conditions, if any, teaching to infime variety cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	that caused the leath energy content of the content	cular A uence of): cillat: usnes of)	Accident	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
the death cert y the attending ched for use	Physician/M	in the past 12 months?	es, outcome pf pregna ]Live birth 2 □ Fetal ]Pregnant at time of do ]Unknown	Ideath 3□	]Ectopic pregnanc ] Other <i>(specify)</i> _	у		23d.	Date of deliv Month	rery Day Year
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ysician is certifi director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No  Hospital	¹ 1 X Inpatient 2 □	ER/Outpatier	nt 3 DOA Oth	26. Place of Dea ner: 4□ Nursing H			Other (Speci	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: T	27. Wanner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28d. Describe	esidence 6 □Other (Specify) be how injury occurred						
spital or A		4 ☐ Homicide determined 200  29a. Certifier 1 ☐ Certifying Physician:	Place of injury - At ho building, etc. (Specify	<i>(</i> )		me, date and place	City or To	vn, State)		al Route Number,
the Hos iin 24 hc the Fun ipletely i	Medical	(Check only 2 Medical Examiner: On one) an	the basis of examina d manner stated.	tion and/or in	vestigation, in my	opinion, death occu	urred at the time,	date and pla	ace, and due	to the cause(s)
with com	M	29b. Signature and title of certifier  Karumui	m · 5			se number 58782			gned (Month, gust 10	Day, Year) 0, 2009
		30. Name and address of person who complete Adedeji Karunwi, M.D.	d cause of death (Item LRH 7300 \	i 23a) (Type, 7an Dus	en Road	Laurel,	1 2070	7		

DHMH 17 Rev 1/2001

Registrar

State 31. Date filed (Month, Day, Year)

AUG 18 2009

32. Tegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:35 A <sup>M</sup> August 19, 2009 Robert Carl Kunde /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Goodwill Mennonite Home Garrett Grantsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Nov 25, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1919 1 M 2 □ F 89 Yrs Washington, DC 214-16-7045 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 814 Bermuda Court 21401 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WW 2 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🙀 No Specify: Specify þ 3 ₩ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Testman Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Kunde Bertha Qualheim ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Enzor/daughter P.O. Box 157, Grantsville, MD 21536 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Country Side Crem. Aug 21, 2009 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sep665 eumaw 179 Miller St., Box 275, Grantsville, MD 21536 **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tra Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 2 X No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA ပ After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: n 24 hours after des he Funeral Directo pletely filled in by th within 2

altimore, Maryland 21215-0036

1 VA 20 State Registrar

29b. Signature and title of certifier

Kent

29c. License number

0066150

29d. Date signed (Month, Day, Year)

Ave Suit 204. Cumberland MD 21502.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nac

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 2:05 P M 2009 Alfred Robert Lueders August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10112 Wildwood Road Kensington Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 579-44-2333 83 Sept. 18, 1925 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Director Maryland Kensington Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10112 Wildwood Road 20895 United States by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates Korean War 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Translation /Linguistics Linguist h and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any Injury or other traumatic event Be Alfred J. W. Lueders ပ Christina Unobtainable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kira K. Lueders / Spouse 10112 Wildwood Road; Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 8/14/2009 Brentwood, MD 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate O up (Final disease or constition resulting in death)

a. Adenocarcinoma of gallbladder Approximate Interval Between Onset and Death **Physician** 3 months > /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed' certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No ospital or Attending Physician: hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No d in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Sid 29c. License number 29d. Date signed (Month, Day, Year) D21531 August 11, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Pushkas, M.D. 11510 Old Georgetown Road, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** Day Year CFFLER 48 ETHEL 2009 /Medical 4b. City, Town, or Location of Death
SILVER SPRING 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 9115 Alton MONTGOMERY Home tarkway If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 16, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 ☐ M 2 🔽 F 1312-28-0429 94 Director Hungary Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminar must be notified at 1ĂYes 2□No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 U.S.A. Completed by Funeral Alton Parkway 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ages 1 and 2 should be filed within nt of Health and Mental Hygiene, if I tem 27 is marked other than or or other traumatic event, The Mental Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zsgmond Kaszirer Leah Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Dr. Robert G. Loeffler/Son 8905 Harvest Square Court Potomac, MD 20854 20a. Method of Disposition 20c. Location - City or Town, State Wallsteh District Chillent Cance 1 Burial 2 Cremation 3 Removal from State Memorial Park 8/17/2009 Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Mem. Chapel 21. Signature of Juneral Service Licensee 1170 Rockville Pike Rockville, MD 20852 I rt1. Enter the disease, or a market in sthat cluse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. F Immediate Cause (Final disease or condition resulting in death) LEART **Physician** CNGESTIVE FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) □Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BRONCHITB RECURRENT 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy perform 1 ☐ Yes 2 No 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a, Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director: within 2 2

with

Kuzi

State Registrar

29b. Signature and title of certifier

M. AAMIR 31. Date filed (Month, Day, Year) AUG 18

30

M. AAMIR ALI, M.D.)

10801

37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

ockwood Drive #200

29d. Date signed (Month, Day, Year)

16/2000

SILVER SPRING, MD

09-06614 Martha Charisse Long

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 28000

			For State Ce	Certificate of Death				Reg. No.			
led	Physicia ical Exami	n/	1. Decedent's Name (First, Middle,Last)  Martha Charisse Long				AL.	ate of Death onth [ Jgust 23, 1		3. Time of Death 1657 hrs	
			Facility Name (if not institution, give street and number)     Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring				4c. County of Death  Montgomery			
	Funeral Director	,	5. Social Security Number 6. Sex 7. Age (In yrs. 578–02–5277 1_M 2XF 44	last birthday) Yrs	If Under 1 Year Months Day			Date of Birth		9. Birthplace (State or Foreign Country) DC	
	death with the reference 23s nust be not	To Be Completed by Funeral Director	,	y, Town or Locati						10d. Inside City Limits  1 Yes 2 X No	
1			10e. Street and Number 9900 Georgia Ave Apt 702		10f. Zip Code 20902			109	g. Citizen of Wha USA		
			11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced  12. Was Decedent Ever in the Armed Forces?  1 Yes 2 No	If Y	as Decedent of H Yes, specify Cuba	n, Mexican, o specify:	Puerto Rica	n, etc.)	White, Specify:	Black	
	15-0036 filed within 72 hours after I Hygiene. 2d other than "natural", c 1, the Medical Examiner 1		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+) 2  Laboratory Technician					done	16b. Kind of Business/Industry  Medical		
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last)  Melvin Lawson			Queen	ie E. I	iong	aiden Surname)		
	Baltimore, MD 21218 permit. Pages I and 2 should be fil Department of Health and Mental P. Important: If item 27 is marked injury or other traumatic event, is		19a. Informant's Name/Relationship (Type, Print )  Queenie E. Long /Mother	14805	Pennfield	Circle	Apt 30	Ol, Sil	ver Spring	s, State, Zip Code)	
			1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	o. Place of Dispo crematory or o tropolita	ther place) in Cremato	ry	Aug 29		Alexandri		
	Balti permit. Departm Imports injury o		21. Signature of Funeral Service Ucensee  22. Name and Address of Facility Francis J. Collins Funeral Home Inc.  500 University Blvd W, Silver Spring, MD 20901								
(	Physician Medical caminer		Approximate Interval Between Cheset and Death  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Cheset and Death  Pulmonary thromboembolism  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
		Examiner									
B	ecuted and - transit										
	Box 68760, the death certificate be executed the attending physician and nod for use as the burial - transit	sician/Medical	X UNPENDED AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unknown  AMENDED  23c. If yes, outcome of pregnant in the past 12 months?  1 Unknown  2 Unknown	2 F	Fetal death Other (Specify)	3 Ectopi	c pregnancy		23d. Date of Month	Day Year	
	that the danced by the	by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Vunknown								
	Division of Vital Records, P.O. Box 681 into Attending Physician: The law requires that the death certifier death.  The aber death.  The this certificate has been signed by the attending land from the former director, page 2 should be detached for use as fell on by the funeral director, page 2 should be detached for use as fell.	pleted	Obesity					24a. Was autop perfo	osy rmed?	Were autopsy findings available orior to completion of cause of death?  Yes 2 No	
	al Rian: Ti	Be C	25. Was case referred to medical examiner? Hospital: A particular of the property of the prope								
	Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate be completely filled in by the funeral director, page	on: To	1 Ves 2 No Impatient 2 Produpatient 3 500 Table of Injury 28b, Tim								
	Division O  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral presences.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	At home, farm, st	reet, factory, offic	ce building, e	etc. 28	or Town,		per or Rural Route Number, City	
	Hospi 24 hou Funer tely fil	Medical Ce	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
4	To the within To the comple		and manner stated.  29b. Signature and title of certifier	7	29c. Lic	ense numbe				ned (Month, Day, Year)	
			30. Name and address of person who completed cause of death ( Zabiullah Ali, M.D. Assistant Medical Examin	Item 23a) ner 111 P	enn Street, E	Baltimore,	MD 2120	01			
		State	31. Date filed (Month Day, Year)		Kil						